

81 30231

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR				
<i>Dawson</i>			<i>S.</i>	<i>Baker</i>		<i>Nov. 29, 1981</i>						<i>4 PM</i>				
3. SEX			4 RACE		5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>male</i>			<i>caucasian</i>		<i>Aug. 20, 1907</i>			74	YRS.			MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
<i>Delaware</i>			<i>U.S.</i>							<i>Talbot</i>						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
<i>Easton</i>			<i>The Memorial Hospital</i>						<i>farmer</i>							
13a STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
<i>Maryland</i>			<i>Talbot</i>		<i>Easton</i>				<i>R.D. #2, Box 282</i>							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
<i>Orra F. Baker</i>						<i>Rosa C. Whitby</i>										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17 INFORMANT			ADDRESS				
no			<i>577-05-5817</i>						<i>Ruth C. Baker</i>			<i>see item 13</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) (c)													<i>Asystole</i> <i>Acute Myocardial Infarction hours</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>11/27/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) did (did not) view the body after death.						<i>11 19 81</i>			<i>11/29/81</i>			<i>19/10</i>		<i>19/11</i>		
22b. SIGNATURE			DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									22e ADDRESS			<i>10/1/81</i>				
<i>T. W. Fauntleroy, M. D.</i>									<i>Easton, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			<i>12-2-1981</i>			<i>Spring Hill</i>			<i>Easton, Talbot, Md.</i>			<i>Dec 4, 1981</i>				
24 FUNERAL DIRECTOR NAME			ADDRESS						25. APPROVED BY REG'D. BYRNS, STARKE, REGISTRAR'S SIGNATURE							
Newnam Funeral Home			<i>Easton, Md.</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once

bemühten, soziale

zu verstehen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

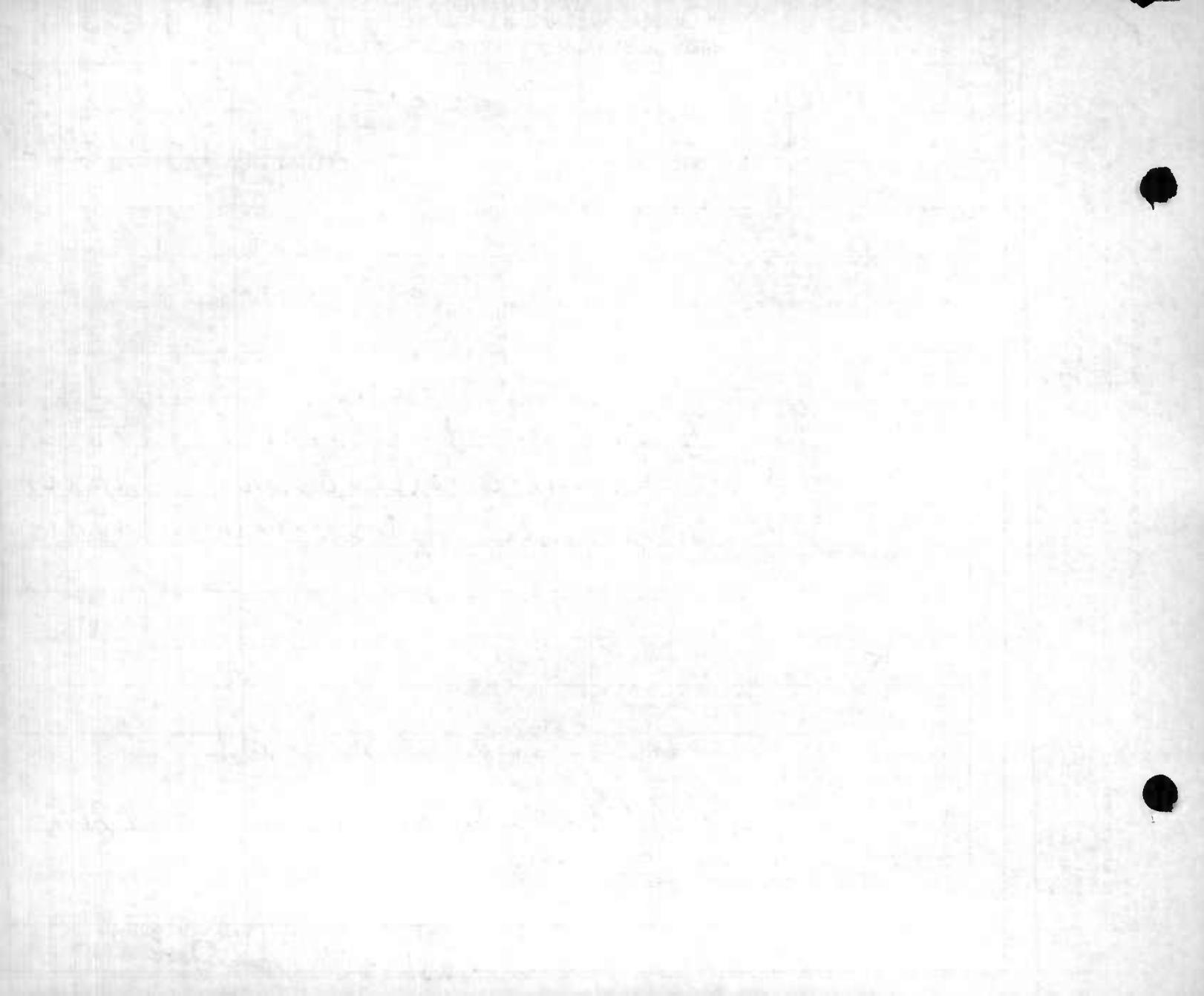
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8   30232							
												REG. NO.							
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR							
(TYPE OR PRINT)			MARY			AUDREY			BATSON			11-20-81	2 <sup>29</sup> M						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR	7b. IF UNDER 24 HRS						
Female			Negro			MONTH DAY YEAR Nov. 9, 1931			50			YRS	MONTHS DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD							
Preston, Md.			U.S.A.						TALBOT										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION - (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
EASTON			MEMORIAL HOSPITAL			Housewife			Own home										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland			Caroline			Preston			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 2, Box 184							
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME						LAST							
FIRST Arthur Stanford			MIDDLE			FIRST Mary Johnson						MIDDLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21655							
No			218-29-4952			Anita Jackson, Rt. 2, Box 184, Preston, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED METASTATIC CARCINOMA																			
1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CARCINOMA OF UTERINE CERVIX																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION — N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Edward S McDonald MD.														DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-20-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																
EDWARD S McDONALD			PO Box 210 EASTON MD 21601																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 28, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Coppins Cemetery			23d. LOCATION CITY OR TOWN Preston, Caroline, Maryland			COUNTY STATE							
24. FUNERAL DIRECTOR NAME Frances Jan Nathan ADDRESS																			
25a. DATE REC'D. BY REGISTRAR NOV 23 1981														25b. REGISTRAR'S SIGNATURE Frances Jan Nathan					

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19. *Leucosia* *leucostoma* *leucostoma* *leucostoma*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30233					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE KNOWN TO OF ESTI- DEATH MATED			2b. HOUR		
Adell			M.			Burchett						11 21 1981			4:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female		White		FEB. 13 1924			57 yrs.							11-21 1981			4:51 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH										
Texas		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot										
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Easton				Memorial Hospital					Housewife								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Md.		Talbot		St. Michaels					Bozman Road			Star Route					
14. FATHER'S NAME FIRST				McDade			15. MOTHER'S MAIDEN NAME FIRST				Heaslet						
Howard							Maurine										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT				ADDRESS						
No				459-20-5469			Harry P. Burchett				Md. St. Michaels,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours					
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis												years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>R. Lane Wroth</i>		EXAMINER'S NAME (TYPE OR PRINT)			R. Lane Wroth, M.D.			ADDRESS			MEDICAL EXAMINER			DATE SIGNED 11-21-81			
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Fort Sam Houston			23d. LOCATION CITY OR TOWN			COUNTY STATE					
Burial			11-25-81			National Cemetery			San Antonio			Bexar Texas					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Newnam Funeral Home						NOV 25 1981			<i>James J. Newnam</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must initial the box.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 3 0 2 3 4	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>MURIEL LUTZ</i>			<i>Butler</i>			<i>November 24 1981</i>	<i>NOVEMBER</i>	<i>24</i>	<i>1981</i>	<i>12 35-12 AM</i>	
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>			<i>Caucasian</i>		<i>Sept 23, 1923</i>	<i>58</i>	<i>MONTHS</i>	<i>DAYS</i>	<i>HOURS</i>	<i>MIN.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Pennsylvania</i>			<i>U. S. A.</i>				<i>TA/bot</i>				
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
<i>EASTON</i>			<i>Memorial Hospital</i>					<i>Aide</i>			
11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			11a. STATE	11b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
			<i>Maryland</i>	<i>Caroline</i>	<i>Denton</i>	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	<i>Campground Road</i>			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		LAST			
			<i>Raymond</i>	<i>Medford</i>	<i>Lutz</i>	<i>Margaret</i>		<i>Cabey</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
<i>No</i>			<i>213184575</i>		<i>Woodrow W. Butler, Denton, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cardiovascular</i> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Cardiovascular of Pancreas.</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
<i>Beth Israel Hospital</i>										<i>24 Nov 81</i>	
22b. SIGNATURE <i>O. C. H. Schmidt MD</i>			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>O. C. H. Schmidt</i>			22e. ADDRESS <i>Centon, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>11/27/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Denton Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Denton</i>		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>More Funeral Home Denton, Md.</i>			ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>NOV 30 1981</i>		25b. REGISTRAR'S SIGNATURE <i>John J.</i>				

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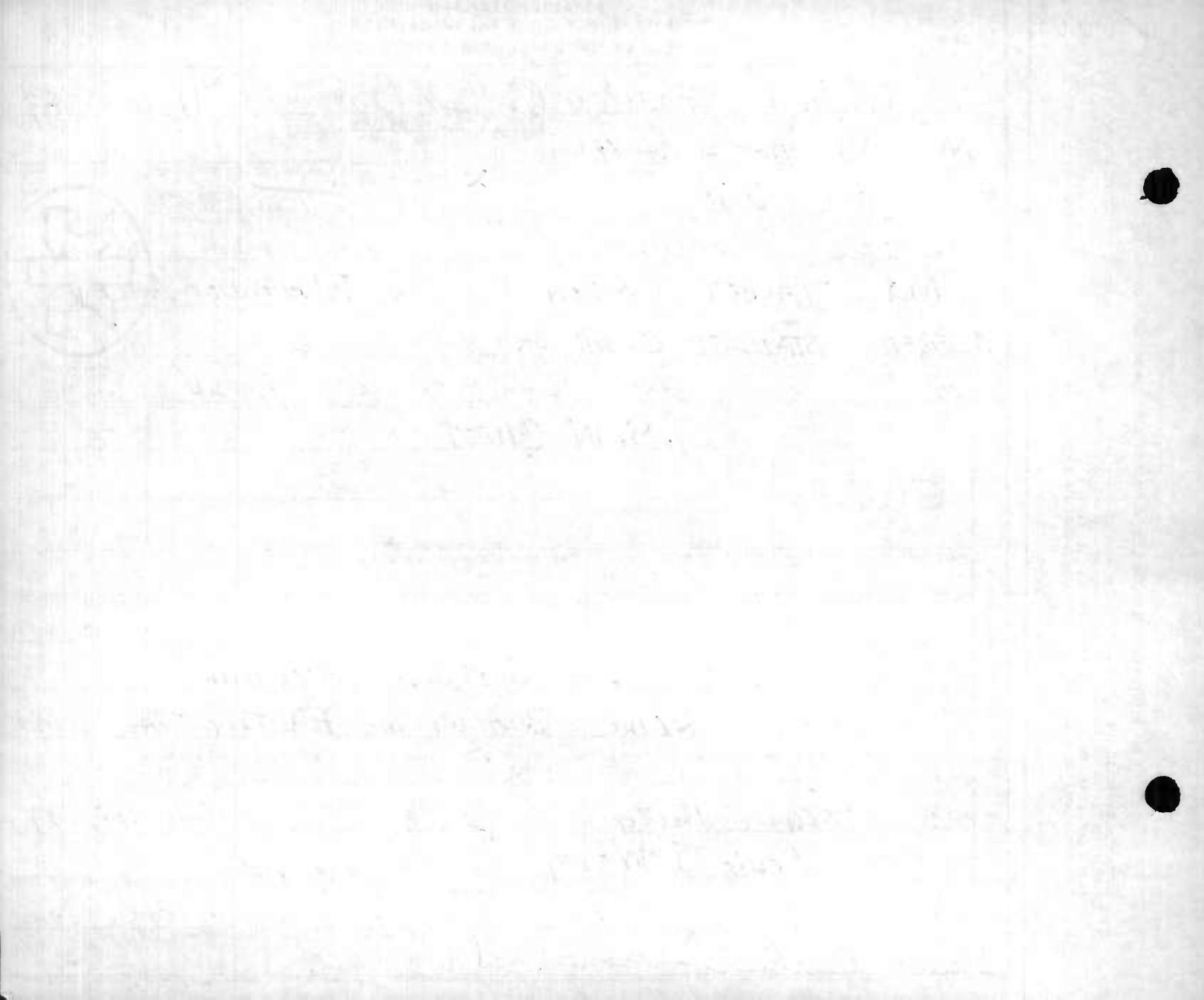


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30235				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR				
<i>Alfred Stanley Cahall, Jr.</i>						<input checked="" type="checkbox"/> 11-6 1981			8	21	8 PM	6:30 PM				
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR			
M		W	MAY 21 1940 41				<input checked="" type="checkbox"/> 19 19						24 HOUR			
7a. BIRTHPLACE FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH								
Milford, Del		USA						<i>Talbot</i>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
EASTON		<i>Memorial</i>			EXRAY Tech.			Hospital								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Md		TALBOT		EASTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			BLACK DOG ALLEY							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> NO					17. INFORMANT		ADDRESS	
<i>ALFRED</i>		<i>STANLEY</i>	<i>Cahall</i>	<i>SR.</i>	<i>MARY</i>			16b. SOCIAL SECURITY NO. 221-24-8614					<i>MARY W. Cahall</i>		R-3 B-533	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>G.S. in. Chest</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													0			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <i>4</i> MONTH <i>NOV</i> DAY <i>6</i> YEAR <i>1981</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			<i>Shotself in Deer gun</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>			21f. LOCATION STREET <i>Boaler</i> CITY/TOWN <i>nr. EASTON</i> COUNTY <i>TAL</i> STATE <i>MD</i>										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Louis S. Shultz</i>			TITLE (SPECIFY) M.D. <i>for d</i>			MEDICAL EXAMINER			DATE SIGNED <i>11-7-81</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>Louis S. Shultz</i>			ADDRESS <i>EASTON MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Nov. 9, 1981</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St Johnstown Cemetery</i>			23d. LOCATION CITY OR TOWN <i>GREENWOOD</i> COUNTY <i>SUSSEX</i> STATE <i>DELA</i>							
24. FUNERAL DIRECTOR NAME <i>William Fleischauer</i>			ADDRESS <i>Greenwood, Del</i>			25a. DATE REC'D. BY REGISTRAR <i>Nov 13 1981</i>			25b. REGISTRAR'S SIGNATURE <i>Jan Nathan</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE 12-4-81 per phone AL REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 3 0 2 3 6								
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 11 20 81 11 40 PM			
<i>Baby mole</i>			<i>Boy</i>				<i>Caldwell</i>								
3 SEX			4 RACE				5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) ---			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 11 20 81 15			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			10. CITY OR TOWN OF DEATH <i>Easton</i> 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital at Easton</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>St. Michaels</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>215 Dodson Avenue</i>			MD.			
14. FATHER'S NAME FIRST <i>James Howard Cisco</i>			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST <i>Karen Caldwell</i>			MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT 21. ADDRESS <i>Karen Caldwell St. Michaels, Md.</i>			22. DATES					
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe asphyxia and shock.</i> DUE TO, OR AS A CONSEQUENCE OF <i>Posterior lateral diaphragmatic hernia</i> (b) <i>7566</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alvin</i> <i>Months</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														22b. DATE SIGNED <i>11-21-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <i>Malak S. Derakhshani, M. D. Easton, Maryland 21601</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Nov 23, 1981</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Thomas Memorial</i>			23d. LOCATION CITY OR TOWN <i>St. Michaels Talbot Md.</i>		23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>Jackson E. Leonard</i>			ADDRESS <i>St. Michaels</i>		25a. DATE REC'D. BY REGISTRAR <i>C2 1981</i>			25b. REGISTRAR'S SIGNATURE <i>Roger J. Leonard</i>							
DHMH - 16 50M 1/B1 (VRA 15, 4)															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8130231	
												REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			11-29-81			2550 M	
MARGARET C. CHAPLIN													
3 SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
female			caucasian			Jan. 3, 1888			93 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
Penn.			U.S.										
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	
13. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 109 Goldsborough St.	
14. FATHER'S NAME FIRST Henry Milo Curry			LAST			15. MOTHER'S MAIDEN NAME FIRST Harriet Girty			LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause, lost DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
no			215-44-5901			Kitty C. Martin			Cronic Congestive Heart Failure Chronic congestive heart failure			(?)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1 fm 19 50 to 29 Nov 19 81, that (I) (not) saw the deceased alive on 14 29 81 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Thurston Harrison			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/30/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thurston Harrison, M. D.			22e. ADDRESS Easton, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 11-30-1981			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Del.			24. FUNERAL DIRECTOR NAME Newnam Funeral Home	ADDRESS Easton, Md.
												REC'D. BY REGISTRAR REGISTRATION NUMBER DEC 5 1981	

1981-00000000000000000000000000000000

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1981-00000000000000000000000000000000

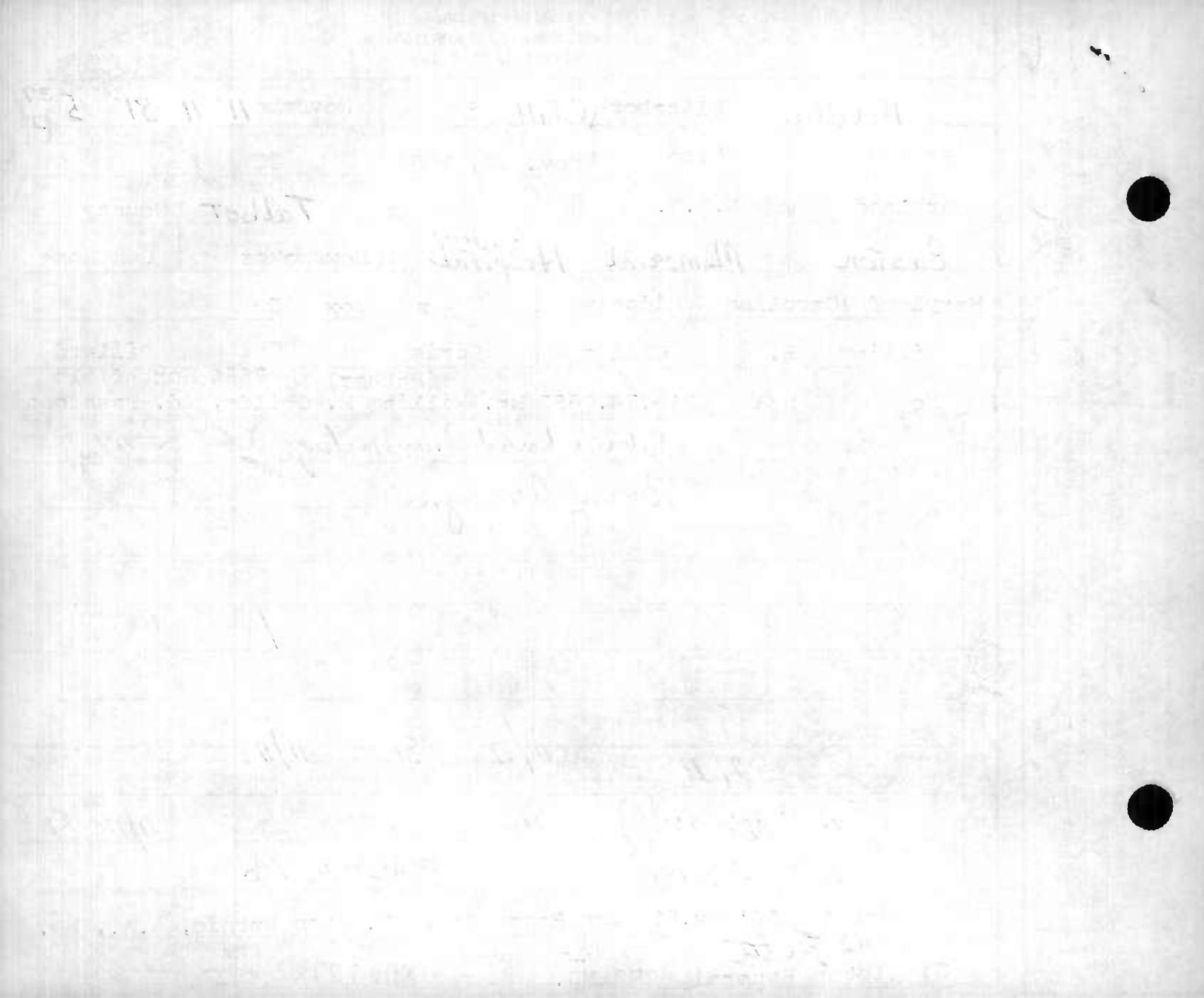
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification page should be detached for use as the burial-transit permit.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8130238		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Marilyn Elizabeth Childs						November 11, 1981						37		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		Nov. 25, 1958			22 yrs.			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.					Talbot County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton		Memorial Hospital		Homemaker			Own Home							
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Ridgely			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 285				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			16. PARENT'S NAME LAST				
William H.				Doris						Dillard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Father) ADDRESS			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			7684 Northfield			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		N/A		219.74.0463			Mr. William H. Childs, Rd. Pasadena						4 days	
4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												Subarachnoid Hemorrhage		
DUE TO, OR AS A CONSEQUENCE OF (b) Berry Aneurysm														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11/7/81 to 11/11/81, that (I) (we) last saw the deceased alive on 11/11/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE W M H Wood		DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/11/81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W M H Wood		22e. ADDRESS EASTON, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 16 Nov. 81			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Pk.			23d. LOCATION CITY OR TOWN Glen Burnie, A.A., MD.						
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS MD.			25a. DATE REC'D. BY REGISTRAR NOV 17 1981			25b. REGISTRAR'S SIGNATURE James Jan Martin						
BP_____														
DHMH - 16 50M 1/81 (VRA 15, 4)														



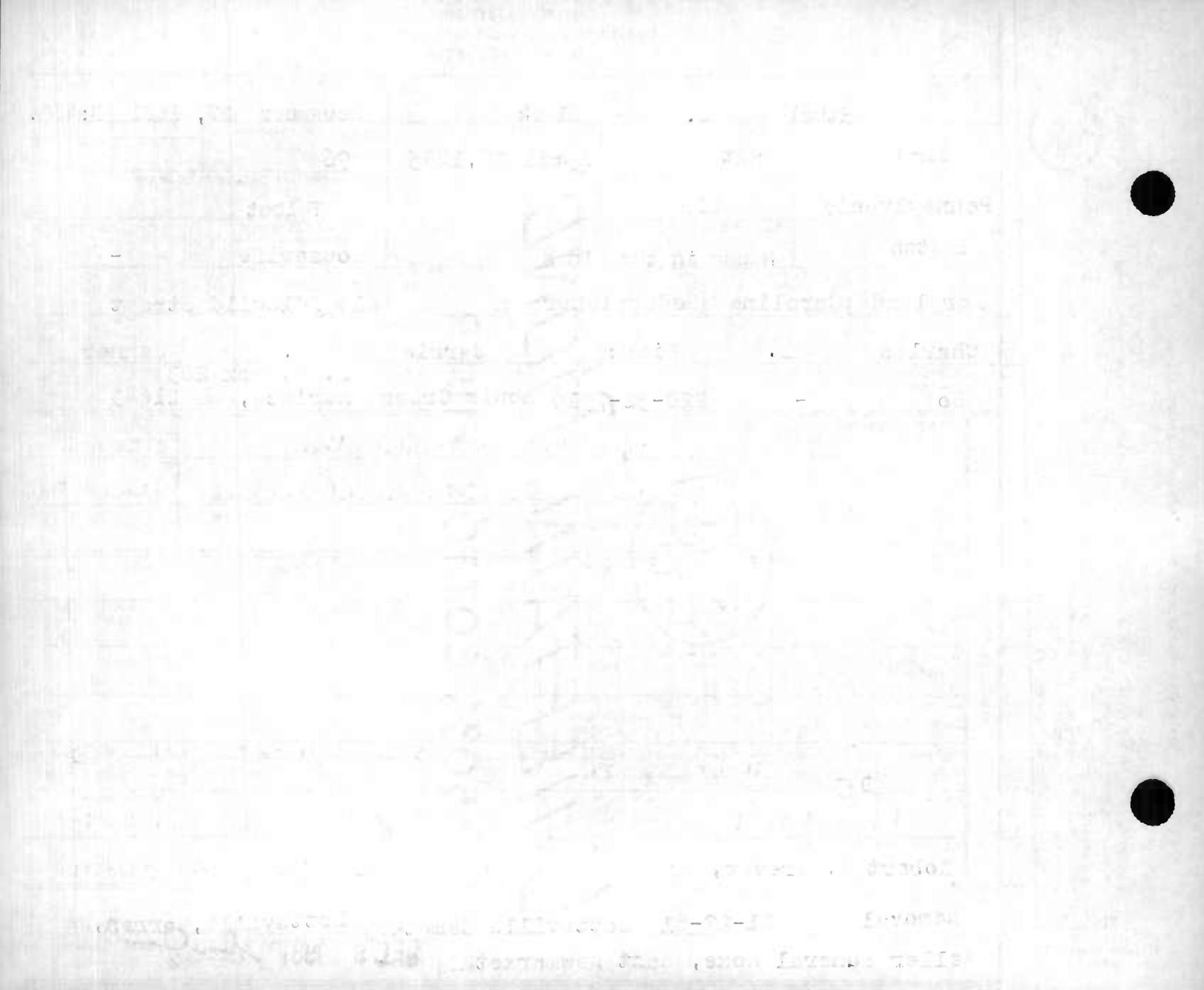
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Star of the Union  
State of MarylandFOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 3 0 2 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Ethel L. Clark						November	27	1981	3:40 PM	
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 MRS. MONTHS DAYS HOURS MIN.	
Female			White	April 28, 1885		96				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton			NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Maryland			13c. CITY OR TOWN Caroline Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 614 Idlewild Street			
14. FATHER'S NAME Charles			MIDDLE E.	LAST Pierce	15. MOTHER'S MAIDEN NAME Carrie E. Jenner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-52-7910		17. INFORMANT Louis Cross Hurlock, MD 21643			P. O. ADDRESS Box 203		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140			VENTRICULAR FIBRILLATION					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 20 min.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE					Uncertain		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 7-4, 1981, to 11-27, 1981, the <input type="checkbox"/> (I) we last saw the deceased alive on 11-16, 1981, and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) we did <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE Robert W. Trever, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-28-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, MD			22e. ADDRESS RD 3			Easton Md. 21601				
23a. FUNERAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11-27-81		23c. NAME OF CEMETERY OR CREMATORIAL Lottsville Cemetery		23d. LOCATION CITY OR TOWN Lottsville, Warren, PA		COUNTY	STATE	
24. FUNERAL DIRECTOR Zeller Funeral Home, East NewMarket MD		25a. DATE REC'D. BY REGISTRAR DEC 9 1981		25b. REGISTRATION NUMBER Thurman						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

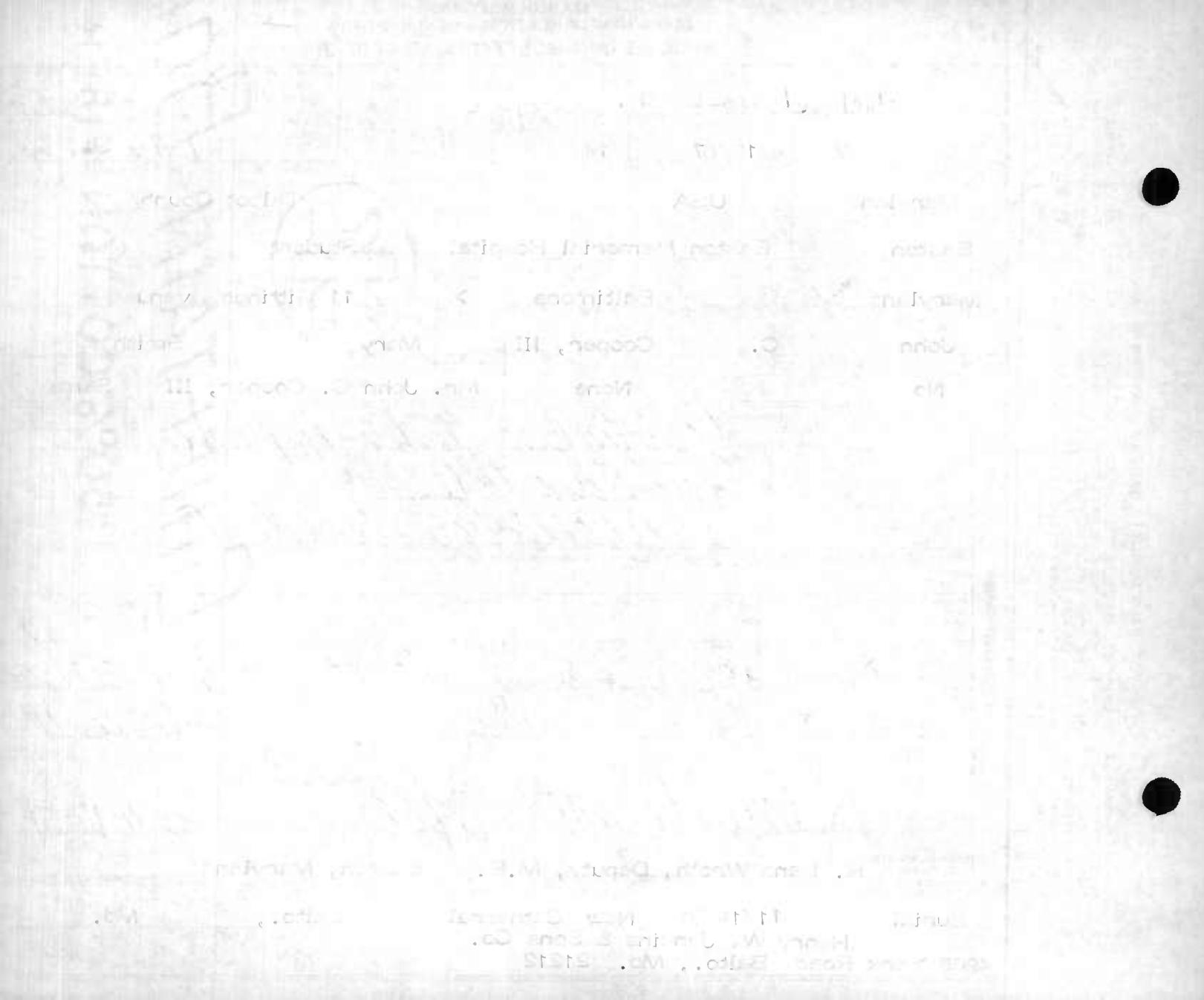
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8130240	
												REG. NO.	
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 05 10 AM	
			Evelyn W. Collins						Nov 28 1981				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 71			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Burrsville, Del.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			MD.	
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) memorial Hosp. Val.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Button Cutter			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1, Box 1	
14. FATHER'S NAME Wilbur Welch						15. MOTHER'S MAIDEN NAME Brooksie Cole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-14-4303			17. INFORMANT Linda Collins, Rt. 1, Box 1, Federalsburg,			ADDRESS Maryland 21632			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>R</u> middle cerebral artery thrombosis 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>Cerebral vascular</u> in softening { DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebrovascular disease</u> years DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes mellitus - ASCVD.C AT</u>													
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from above, (I) we did (did not) view the body after death.			22b. SIGNATURE CRUBAIN / CT DAHLER			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/28				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Calum Bain, M.D. BAIRN													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 30, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Concord Cemetery			23d. LOCATION CITY OR TOWN NR. Denton, Caroline				
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home			ADDRESS 216 N. Main St. Federalsburg			25a. DATE REC'D. BY REGISTRAR DEC 3 1981			STATE Maryland				
BP _____													
DHMH-1650M 1/B1 (VRA 15, 4)													

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2712

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1-30241									
1- STATE REGISTRAR																					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR					
MICHAEL H. COOPER											<input checked="" type="checkbox"/>		11	16	1981	8:00 AM					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 4/13/67		DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS.		7. IF UNDER 1 YR. MONTHS 0		IF UNDER 24 HRS. DAYS 0		HOURS 0		MIN. 0		2c. DATE PRONOUNCED DEAD 11-16 1981		2d. HOUR 8:00 AM	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/>		NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County		MD.							
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY None							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES		13e. STREET ADDRESS 11 Gittings Avenue													
14. FATHER'S NAME John		MIDDLE C.		LAST Cooper, III		15. MOTHER'S MAIDEN NAME Mary															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John C. Cooper, III		ADDRESS Same															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), etc.) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUETO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. 8151														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUETO OR AS A CONSEQUENCE OF (b) DUE TO OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 3:30 P.M.			21b. TIME OF INJURY HOURS MONTH DAY YEAR 11/16 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car went off road, struck utility pole															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, WORK, FACTORY, FARM, ETC.) Highway			21f. LOCATION Mile Marker 1150		CITY OR TOWN Balto.		COUNTY Talbot Co. Md.											
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																		
ACTUAL SIGNATURE R. Lane Wroth, Deputy, M.D.			TITLE (SPECIFY) M.D.										MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, Deputy, M.D.			ADDRESS Easton, Maryland										DATE SIGNED 11-17-81								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/19/81			23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION CITY OR TOWN Balto.		COUNTY Md.		STATE								
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road			ADDRESS Balto., Md. 21212			25a. DATE REC'D. BY REGISTRAR NOV 19 1981		25b. REGISTRAR'S SIGNATURE Frances Jean Hartman													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8130242											
												REG. NO.											
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)				FIRST Elsie	MIDDLE Mae	LAST Cunningham	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR											
	<i>Elsie</i>				<i>Elsie</i>	<i>M.</i>	<i>Cunningham</i>	. .	11	7	81	3:25 PM											
3. SEX	4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)														
Female	White				MONTH March	DAY 15,	YEAR 1898	83															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH														
Massachusetts	USA								<i>Talbot</i>														
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY														
<i>Caston</i>	<i>Memorial Hospital</i>				<i>Wife</i>				<i>Home</i>														
13a. STATE 13b. COUNTY	13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS														
Massachusetts	Norfolk				Quincy				Quincy Housing Developement														
14. FATHER'S NAME	FIRST Louis	MIDDLE Porter	LAST Kneeland	15. MOTHER'S MAIDEN NAME				FIRST Mamie	MIDDLE Ellen	LAST Tibbets	ADDRESS P.O. Box 44												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY														
No	025-05-0359-D				William E. Kneeland, Chester, Md. 21619								IMMEDIATE CAUSE (a) <i>renal failure</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months.</i>									
5900												DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic pyelo nephritis</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(c)		DUE TO, OR AS A CONSEQUENCE OF <i>years.</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
<i>iron deficiency anemia + (2) ill pneumonia</i>												19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET							
22a. I certify that (I) (this hospital) attended the deceased from <i>11/17/81</i> to <i>11/17/81</i> , that (I) (we) last saw the deceased alive on <i>11/7/81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.												22b. SIGNATURE <i>Albert T. Dawkins</i>											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT T. DAWKINS</i>												22d. DEGREE <i>CRW. BAIN</i>				22e. ADDRESS FOR <i>CRW. BAIN, M.D.</i>							
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial												23b. DATE Nov. 11, 1981				23c. NAME OF CEMETERY OR CREMATORIAL Rowley Cemetery				23d. LOCATION CITY OR TOWN Rowley,			
24. FUNERAL DIRECTOR NAME <i>Barton Bros.</i>												25a. DATE REC'D. BY REGISTRAR NOV 13 1981				25b. REGISTRAR'S SIGNATURE <i>Jones Jan Harten</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81	30243		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
William E					Dust	Nov 6 81						1 am M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			Cau.			MONTH 11 DAY 11 YEAR 99			81			MONTHS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS		MONTHS	
Md.			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot			MD.		DAYS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Easton			Memorial Hospital									Carpenter			
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Md.			Caroline			Greensboro			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt 1 Box 379			
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
Henry			Dust			Alice Tasker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no			219-01-3085			Magdalene Dust			Greensboro, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Colonic Carcinoma															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia; Parkinson's Disease															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1977, 19, to Nov 6, 1981, that (I) we last saw the deceased alive on 11-5-81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Terry P. Detrich, M.D.												DEGREE	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Terry P. Detrich, M.D.												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial												23b. DATE 11-9-81	23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery	23d. LOCATION City or Town Greensboro, Car.	County Md.
24. FUNERAL DIRECTOR NAME John E. Boulais												25a. DATE OF DEATH NOV 16 1981	25b. NAME OF DEATH REGISTRAR Frances Jean		

WILLIAM T. GREENE  
1000 UNIVERSITY AVENUE

Seattle, Wash. 98101

Today's date: 10/10/88 Dear Yann:

Subject: Your shopping list for 10/10/88

On

10/10/88

10/10/88

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Dr. Danks

D. Virginia Fisher - R.C. #124691-11/23/81

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 3 0 2 4 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			Virginia	H. S.	Fisher	November	23	1981		12:10 A.M.		
1c. SEX		1d. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		White		Sept. 2 1893			88			MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Maryland		U. S. A.					Talbot			MONTHS	DAYS	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton		House in the Pines			School Teacher							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS						
Maryland		Talbot		Oxford								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		Thomas	Bordle	Stevart			Mary	Virginia	Willie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
(If Yes, give war or dates)		213-42-2802			Mrs. James M. Connell St. Louis Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						chronic renal insufficiency 3 months						
DUE TO, OR AS A CONSEQUENCE OF (b) arterio sclerotic cardio-												
DUE TO, OR AS A CONSEQUENCE OF (c) vascular disease						years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) (R) mid ole cerebro artery thrombosis + coronary artery disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/20 1978, to 11/23 1981, that (I) we <input checked="" type="checkbox"/> saw the deceased alive on 11/22 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did/did not view the body after death.												
22b. SIGNATURE <i>Albert J. Danks Jr. MD</i>						DEGREE						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albert J. Danks Jr. MD</i>						22d. DATE SIGNED 4/23/81						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Nov. 25		23c. NAME OF CEMETERY OR CREMATORY Oxford		23d. LOCATION CITY OR TOWN Oxford		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 30 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Danks</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM 18: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 4 5
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
					Geib	6 13 81						9:28 M
3. SEX		Male	4. RACE		Caucasian	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
						June 13, 1981					Stillborn	YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Maryland	7b. CITIZEN OF WHAT COUNTRY?		U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
								Talbot				
10. CITY OR TOWN OF DEATH		EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
					Hospital							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												MD.
13. STATE		Maryland	13a. COUNTY		Caroline	13c. CITY OR TOWN		Ridgely	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
											Rt. 1, Box 237 B	
14. FATHER'S NAME		Randy James	MIDDLE	LAST	Geib	15. MOTHER'S MAIDEN NAME		Merle	MIDDLE	Van Wyen	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		no	16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
								Shari Van Wyen, Ridgely, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>7651</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immaturity</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED  WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>M. Derayk Shan</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. DERAYK SHAN</u>		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/15/81		23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery		23d. LOCATION CITY OR TOWN Denton		COUNTY Caroline	STATE Md.			
24. FUNERAL DIRECTOR NAME <u>Moore Funeral Home</u>		ADDRESS <u>Devon, Md</u>		25a. DATE REC'D. BY REGISTRAR JUN 22 1981		25b. REGISTRAR'S SIGNATURE <u>John J. Blaney</u>						

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MANUFACTURERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH.						81 30246	
1 - FOR STATE REGISTRAR		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>JUANITA</i>	MIDDLE <i>S.</i>	LAST <i>GREENE</i>	20. DATE OF DEATH MONTH DAY YEAR		26 HOUR
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female		Caucasian		Sept. 27, 1925	56		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Texas</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>TALBOT County</i>	
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>EASTON MEMORIAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>social worker</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>AnneArundleArnold</i>		13c. CITY OR TOWN		12b. KIND OF BUSINESS OR INDUSTRY State of Md.	
14. FATHER'S NAME FIRST <i>Charles</i>		MIDDLE <i>L.</i>	LAST <i>Smith</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Eura</i>		MIDDLE	LAST <i>Bacon</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>459-30-2729</i>		17. INFORMANT		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of breast</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>11-27 1981</i> to <i>11-26 1981</i> , that (I) (we) last saw the deceased alive on <i>11-25 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death							
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE				22c. DATE SIGNED <i>11-26-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Carney, M.D.</i>		22e. ADDRESS <i>Easton, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-1-81</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cem.</i>		23d. LOCATION CITY OR TOWN <i>Easton</i>	
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>		25a. ADDRESS <i>Easton, Md.</i>				25b. DATE REC'D. BY REGISTRAR <i>NOV 30 1981</i>	
DHMH - 16 50M 1/B1 (VRA 15, 4)							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit point. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8130247		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>LARRY</i>					<i>Griffith</i>	<i>11 9 81</i>					<i>22 P</i>			
3. SEX		<i>m</i>	4. RACE		<i>w</i>	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
						<i>July 10 1910</i>						<i>71</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		<i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY?		<i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		<i>Memorial Hosp c Easton</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
							<i>Laborer</i>							
13a. STATE		<i>Maryland</i>	13b. COUNTY		<i>Dorchester</i>	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
						<i>Federalsburg</i>								
14. FATHER'S NAME		FIRST <i>John</i>	MIDDLE		LAST <i>Griffith</i>	15. MOTHER'S MAIDEN NAME			FIRST <i>Carrie</i>	MIDDLE	LAST <i>Johnson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		<i>n/a</i>	16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
			<i>222-07 3023</i>		<i>Mrs. Betty Bramble</i>			<i>Federalsburg, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>4100 Acute Myocardial Infarction</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) <i>ASHT with Chronic CHF</i>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>10/14/81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						<i>9/20 81</i>			<i>10/14/81</i>			<i>19 27</i>		
22b. SIGNATURE <i>John Wood</i>						DEGREE <i>J.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11/19/81</i>		
22d. PHYSICIAN'S NAME (IN CHARGE) <i>John Wood</i>			22e. ADDRESS <i>Easton, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 12			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest			23d. LOCATION CITY OR TOWN <i>Federalsburg</i>			COUNTY <i>Car.</i>	STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Eduard Killianam</i>			ADDRESS <i>Federalsburg, Md.</i>			25a. DATE REC'D. BY REGISTRAR NOV 18 1981			25b. REGISTRAR'S SIGNATURE <i>James Jan Walker</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81	30248					
										REG. NO.						
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Ormond E. Haddaway						Nov. 1, 1981						7:40 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Caucasian			JAN 7 1905			76			MONTHS	DAYS	HOURS	MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton			The Memorial Hospital			Waterman										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Talbot			Wittman						Cummings Road				
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME										
FIRST			Haddaway			FIRST			LAST							
Ernest						Nettie			Colgan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			218-07-7231			Lucy M. Haddaway			Wittman, Md			2 mos				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CEREBRAL VASC. ACCIDENT						
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost										DUE TO, OR AS A CONSEQUENCE OF (b) AS CVD, HEART BLOCK						
										DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 10-31, 1981, to 11-1, 1981, that (I) (we) last saw the deceased alive on 11-1, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22b. DATE SIGNED 11-2-81						
22c. SIGNATURE <i>Stephen P. Carney</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			22e. ADDRESS Easton, Md. 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11-4-81			23c. NAME OF CEMETERY OR CREMATORIAL Tilghman Wesleyan			23d. LOCATION CITY OR TOWN Tilghman Talbot Md			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md. 21601			25. DATE REC'D. BY REGISTRAR/26. REGISTRAR'S SIGNATURE NOV 5 1981 <i>James J. Warken</i>										
BP _____																
DHMH - 16 50M 1/81 (VRA 15, 4)																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

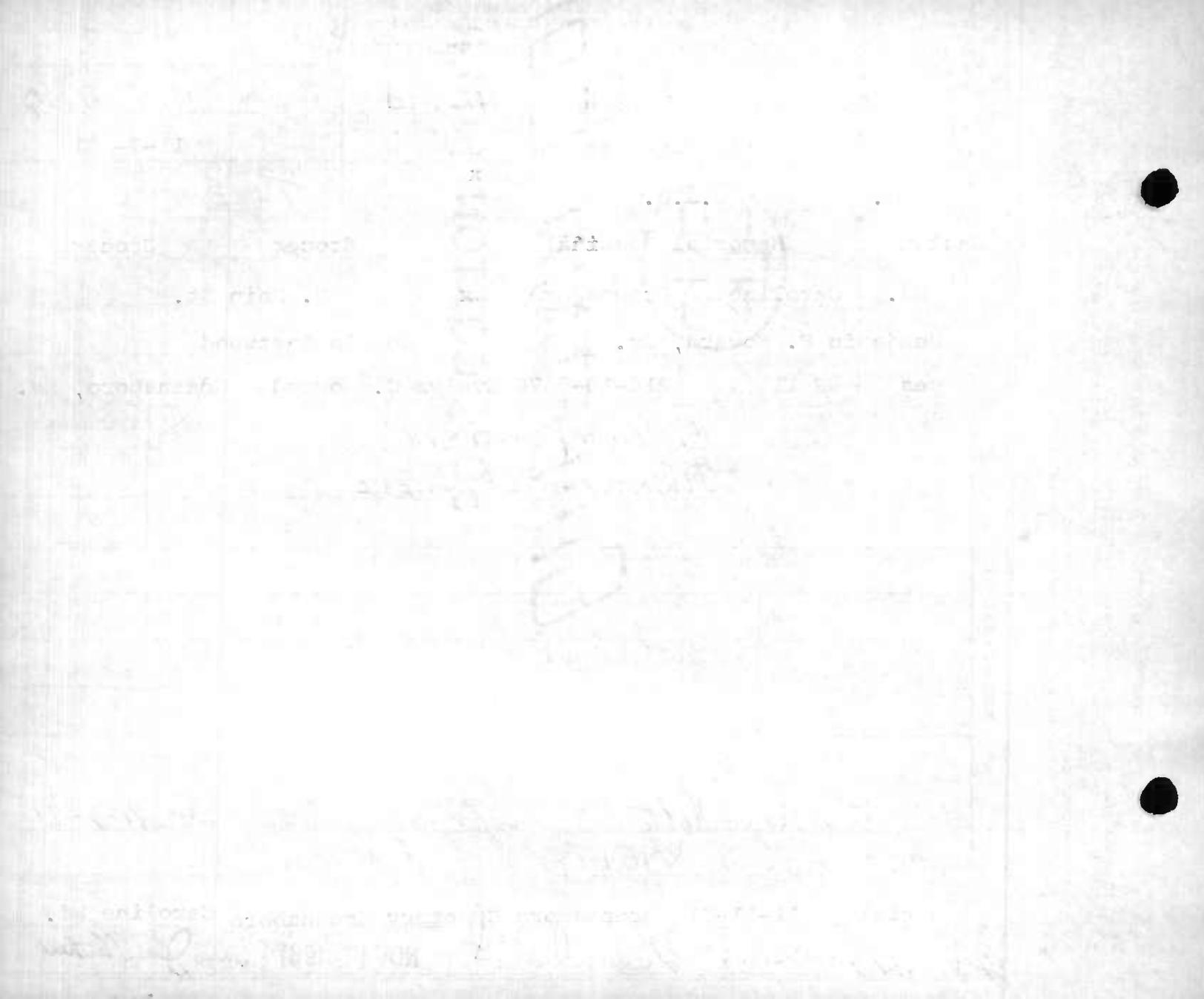
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81	30249
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Carrie E. Holden</i>						<i>November 1, 1981</i>						<i>10 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
<i>Female</i>			<i>White</i>			<i>February 17, 1895</i>			<i>86</i>			<i>IF UNDER 24 HRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTH	
<i>Queen Anne Co., Md.</i>			<i>U.S.A.</i>						<i>Baltimore</i>			<i>MD.</i>	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Easton</i>			<i>The Memorial Hospital</i>			<i>Housewife</i>			<i>Own home</i>				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Caroline</i>			13c. CITY OR TOWN <i>Federalsburg</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>513 Old Denton Road</i>	
14. FATHER'S NAME FIRST <i>Charles S. Boone</i>			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST <i>Mamie Faulkner</i>			MIDDLE			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
<i>No</i>			<i>305-12-3467</i>			<i>Evelyn Hubbard, 513 Old Denton Rd., Md. 2163</i>			<i>Federalsburg,</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>4360</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  { DUE TO, OR AS A CONSEQUENCE OF (b)  DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>10-25-1981</i> , to <i>11-1-1981</i> , the <input type="checkbox"/> (we) last saw the deceased alive on <i>10-25-1981</i> , and that <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.												22c. DATE SIGN <i>11/19/81</i>	
22b. SIGNATURE <i>Thomas Fauntleroy, M.D.</i>			22d. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS <i>Easton, Md. 21601</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN COUNTY STATE				
<i>Burial</i>			<i>Nov. 4, 1981</i>			<i>Hillcrest Cemetery</i>			<i>Federalsburg, Caroline, Md.</i>				
24. FUNERAL DIRECTOR NAME <i>Frances Hawkins Bay 43 Federalsburg, Md.</i>												25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1981</i>	
												25b. REGISTRAR'S SIGNATURE <i>Charles Van Wart</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30250	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR 8:05 M
<i>Benjamin Franklin Howard</i>						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	1	1981	24 HOUR	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD		
M		W	11-17-16	64 yrs.							11-7-1981	M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<i>TALBOT</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital					Grocer			Grocery			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS N. Main St.					
Md.		Caroline		Greensboro									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
		Benjamin F.	Howard	Sr.	Sophia Eastwood								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT		ADDRESS							
		218-10-9676		Evelyn C. Howard		Greensboro, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY occlusion</i> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <i>CORONARY ARTERY DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		<i>Louis S. NELTY</i>										TITLE (SPECIFY) M.D. Jr. 3	
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER										DATE SIGNED 11-7-81	
EXAMINER'S ADDRESS		EASTON											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		11-11-81		Greensboro Cemetery				Greensboro		Caroline		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<i>John E. Boudais</i>		<i>Greensboro</i>		NOV 10 1981		<i>Frances Jean Hartman</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8   30251					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Lee C. Hummel						November 18, 1981						7:25A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Caucasian		JAN. 5 1904			77			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Talbot MD.					
New Jersey		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		House in the Pines										Physician		Medical	
13a. STATE N.J.		COUNTY Salem		13c. CITY OR TOWN Salem			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 109 West Broadway					
14. FATHER'S NAME Lester		MIDDLE		LAST Hummel			15. MOTHER'S MAIDEN NAME Hannah			LAST Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Jonathon A. Hummel			ADDRESS Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular insufficiency &amp; 4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>to arteriosclerotic cardiovascular disease</i> (c) <i>DUE TO, OR AS A CONSEQUENCE OF mid brain stroke</i> <i>DUE TO, OR AS A CONSEQUENCE OF disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinson's disease</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/17 1979</i> to <i>11/18 1981</i> , the (II) (we) lost the deceased during the above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>Albert T. Dawkins Jr. MD</i>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 14 N. Aurora St.			22f. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE SIGNED <i>11/18/81</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Shiloh 7-Day Baptist			23d. LOCATION CITY OR TOWN Shiloh Cumberland N.J.		23e. COUNTY STATE						
Burial		11-21-81													
24. FUNERAL DIRECTOR NAME		ADDRESS Newnam Funeral Home			25a. DATE READ BY REGISTRAR OR REGISTRAR'S SIGNATURE <i>NOV 23 1981 Frances Jean Harten</i>										

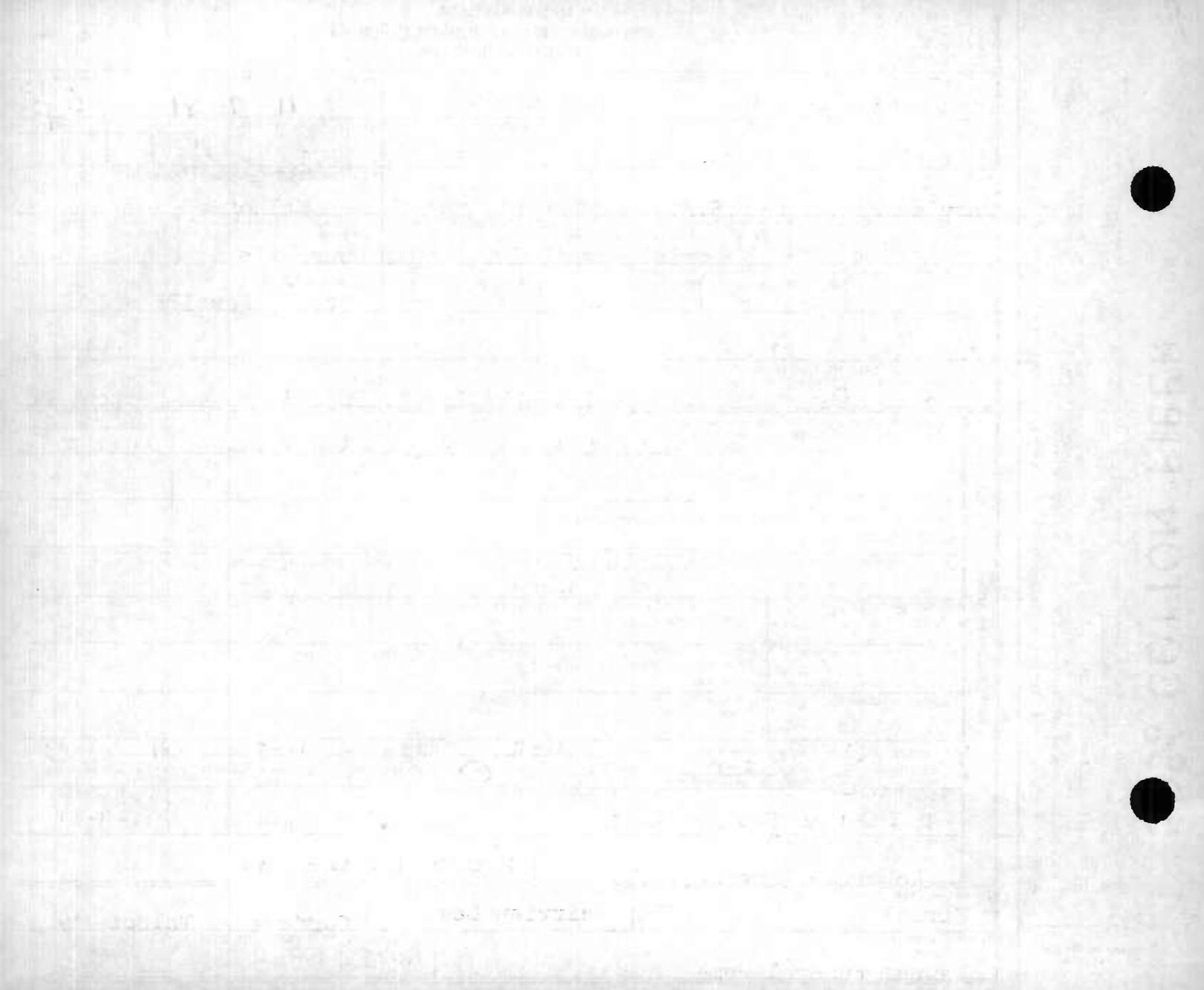


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 81 30252		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11-7-81									2b. HOUR 5 PM		
1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Elizabeth</i>			MIDDLE <i>HUTCHISON</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>DEC. 3 1909</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>71 YRS</i>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
10. CITY OR TOWN OF DEATH <b>Easton</b>			13b. COUNTY <b>Talbot</b>			13c. CITY OR TOWN <b>Easton</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>Rt. 2, Box 178</b>		
14. FATHER'S NAME FIRST <b>James</b>			MIDDLE <b>Elmer</b>			LAST <b>Swann</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Minnie</b>			LAST <b>Taylor</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-74-7904</b>			17. INFORMANT <b>Phillip L. Hutchison</b>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic malignant melanoma Uncertain</i> 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-2, 1979, to 11-7, 1981, that (I) well- saw the deceased alive on 8-17, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.														
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>11-7-81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert W. Trever, M.D.</b>			22e. ADDRESS <b>R.D. 3 Easton, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-10-81</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview Cem.</b>			23d. LOCATION CITY OR TOWN <b>Cordova</b>			COUNTY STATE <b>Talbot Md</b>		
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1981</b>			25b. REGISTRAR'S SIGNATURE <i>James Jan Hartman</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon copies. Page 1 and 2 should be filed - Item 22c should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at Item 18 above, any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 3 0 2 5 3	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>John</i>	MIDDLE <i>HARRISON</i>	LAST <i>Kemp. SR.</i>	20. DATE OF DEATH MONTH DAY YEAR			21. HOUR 1/2 HOUR AM PM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH MARCH YEAR 1894			6. AGE (IN YEARS LAST BIRTHDAY) 87		
7a. BIRTHPLACE COUNTRY <i>MARYLAND</i>			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>TALBOT</i>		
11. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN			12b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		
13a. STATE MARYLAND			13b. COUNTY TALBOT			13c. CITY OR TOWN ST. MICHAELS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST CHARLES ALBERT KEMP			15. MOTHER'S MAIDEN NAME CORDELIA EMMA HARRISON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-16-9229			17. INFORMANT MARGARET E. KEMP			18. ADDRESS 108 E. CHESTNUT ST. ST. MICHAELS, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Myocardial infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASHTO</i> (c) <i>COPD</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>COPD</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED <i>NOT WHILE AT WORK</i> <input type="checkbox"/> <i>AT WORK</i> <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/12</i> 1981, to <i>11/12</i> 1981, that (I) (we) last saw the deceased alive on <i>11/12</i> 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>11/12/81</i>	
22b. SIGNATURE <i>Wm Wood</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm Wood</i>			22e. ADDRESS <i>EASTON, MD</i>								
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>			23b. DATE NOV. 16, 1981			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>OLIVET CEMETERY ST. MICHAELS TALBOT Md.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Spencer &amp; Leonard St. Michaels Md</i>			25a. DATE REC'D. BY REGISTRAR NOV 17 1981			25b. REGISTRAR'S SIGNATURE <i>James Jan Walker</i>					
DHMH - 16 50M 1/81 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8   30254				
												REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			<i>Willis J. Kincaid</i>			KINCAID			11-10-81						25	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 7 DAYS		
Male			Cauc.			March 4, 1931			50			MONTHS	DAYS	HOURS	MIN.	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
West Virginia			USA						Talbot			Reichhold Chem.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton			Memorial Hospital			Yard Man										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Queen Anne			Sudlersville						RFD Box 14				
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			MIDDLE			LAST	
Cleamon			M. Kincaid						Mary			Evans				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no			235-46-0806			Gladys Kincaid *wife* (same)										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC MALIGNANT MELANOMA</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 mo</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (b) _____																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-3 1981</i> to <i>11-10 1981</i> , that (I) (we) last saw the deceased alive on <i>6-10 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.																
22b. SIGNATURE <i>Stephen P. Carney</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-11-81</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Carney, M.D.</i>			22e. ADDRESS <i>Easton, Md. 21601</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL SUDLERSVILLE CEM.			23d. LOCATION CITY OR TOWN <i>Sudlersville, Q.A.</i>			STATE <i>MD</i>				
Burial			Nov. 13, 1981													
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
EDW. Fellows & Son Funeral Home			Millington			NOV 13 1981			Dances Van Wart							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8130255			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	7b. HOUR 10 <sup>30</sup> AM			
ISAAC C KINDER						11 1 81									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Negro		Month Day Year August 10, 1919			62			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Mannine, S.C.		U.S.A.					TALBOT								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton, Md.		EASTON MEMORIAL HOSP.			Road Construction			State							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Caroline		Preston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 2						
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Isaac Kinder					Florence Scott										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
No		251-07-9585		Bertha Kinder, Rt. 2, Preston, Maryland 21655											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 98hr			
4810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal Failure															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/2 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												1979, 19, to 11/1 1982			
22b. SIGNATURE Wood		22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/19/81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wood		22e. ADDRESS EASTON MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 14, 1981		23c. NAME OF CEMETERY OR CREMATORIAL Coppins Cemetery			23d. LOCATION CITY OR TOWN Preston, Caroline, Maryland			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME FRANCIS HAWKINS F.H., Box 43 FEDERALSBURG, MD		25d. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE NOV 16 1981 Francis Jan Martin													



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/trust point. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 5 6			
												REG. NO.			
1. DECEASED NAME <b>Stanislaus Kolakowski</b> LAST												2a. DATE OF DEATH MONTH DAY YEAR			
STANLEY LEON KOŁAKOWSKI												Nov. 30, 81			
3. SEX		4. RACE		5. DATE OF BIRTH		16. AGE (IN YEARS LAST BIRTHDAY)		26. HOUR							
Male		White		Aug. 11 1906		75		4 <sup>16</sup> / <sub>12</sub> P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		17. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Baltimore, Md.		USA				TALBOT									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)													
EASTON		EASTON Memorial Hosp.													
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Queen Anne</b> 13c. CITY OR TOWN <b>Queenstown</b>												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 189 Bennett Point Rd.</b>	
14. FATHER'S NAME FIRST <b>Adolph</b> MIDDLE <b>Kolakowski</b> LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Josephine</b> MIDDLE <b>Popiolo</b> LAST													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES)		17. INFORMANT		605 Toussaint Rd.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes		WWII		213 05 2437		Joan Goode Edgewood, Md. 21040		hours							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable Sepsis</b> <b>5335</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ruptured duodenal peptic ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>David A. Stout</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/11/81</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David A. Stout</i>		22e. ADDRESS <b>Easton Memorial Hosp.</b>													
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>12/5/81</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Stanislaus Cemetery</b>		23d. LOCATION CITY <b>Baltimore</b> STATE <b>Md.</b>									
24. FUNERAL DIRECTOR <i>Jerry F. Karpinski</i>		25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1981</b> 25b. REGISTRAR'S SIGNATURE <i>James J. Muller</i>													
Bohdzinski Funeral Home PA 1407 Old Eastern Ave															



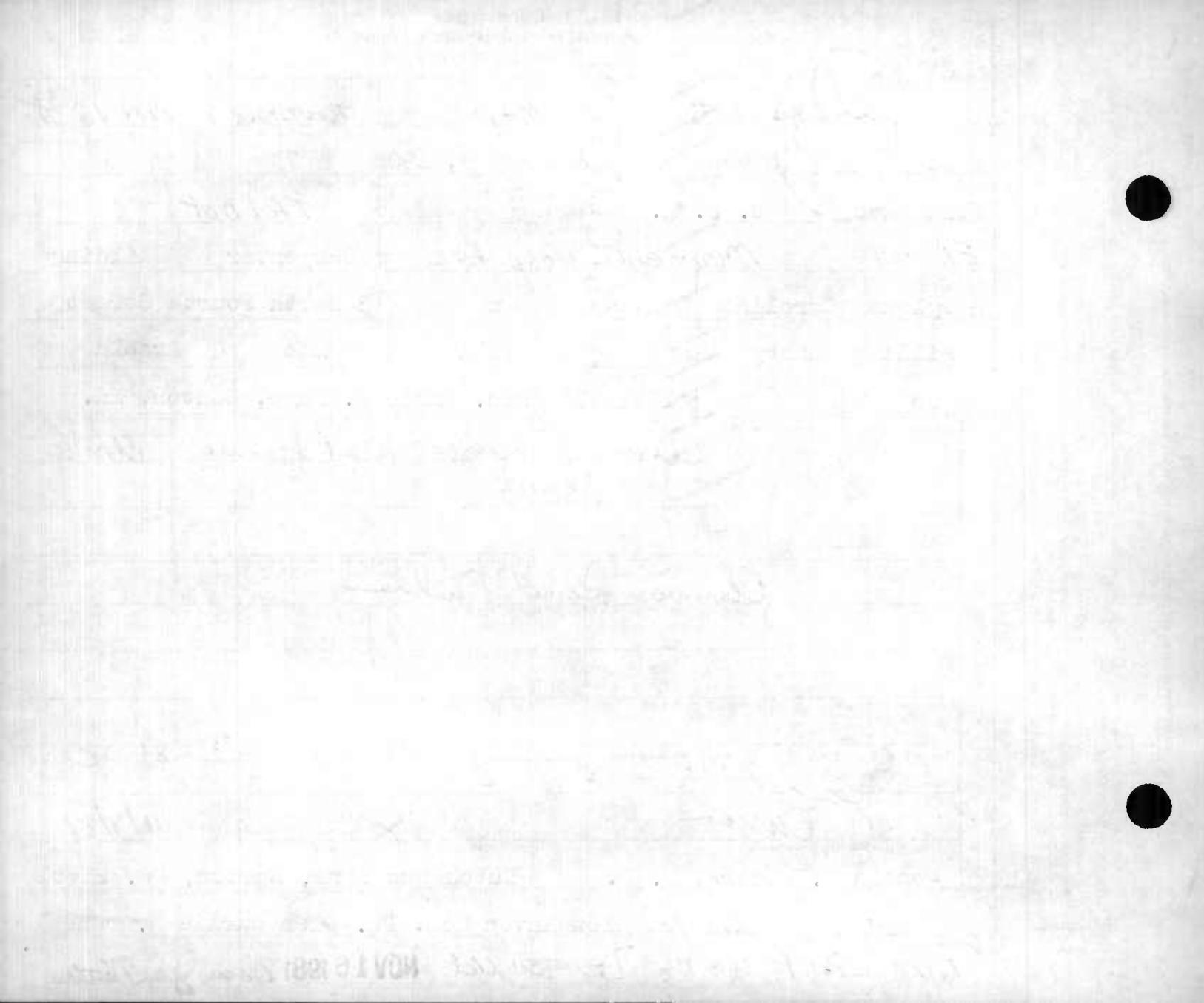
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR	
Lloyd B. Mayo						November 8	1981	12	35	12 35 AM	
1. SEX <b>Male</b>		4. RACE Caucasian		5. DATE OF BIRTH Month Day Year January 3, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b>					
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Denton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13 North Fourth Street</b>			
14. FATHER'S NAME FIRST <b>William</b>		MIDDLE <b>Emory</b>		LAST <b>Mayo</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b>		MIDDLE <b>Mae</b>		LAST <b>Arnold</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>415225276</b>		17. INFORMANT <b>Mrs. Annie S. Mayo, Denton, Md.</b>		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Chronic Congestive Heart Failure</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Chronic Renal Failure</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) this hospital attended the deceased from <b>11/8 1981</b> to <b>11/8 1981</b> , that (I) we last saw the deceased alive on <b>11/8 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we certify, did not see the body after death.)											
22b. SIGNATURE <b>Donald T. Lewers, M. D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/9/81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald T. Lewers, M. D.</b>		22e. ADDRESS <b>Dutchmans Lane, Easton, Md. 21601</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/10/81</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Glen Burnie</b>		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <b>RANDOLPH P. MOORE Denton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James Jean Hartman</b>							
DHMH - 16 50M 1/81 (VRA 15, 4)											

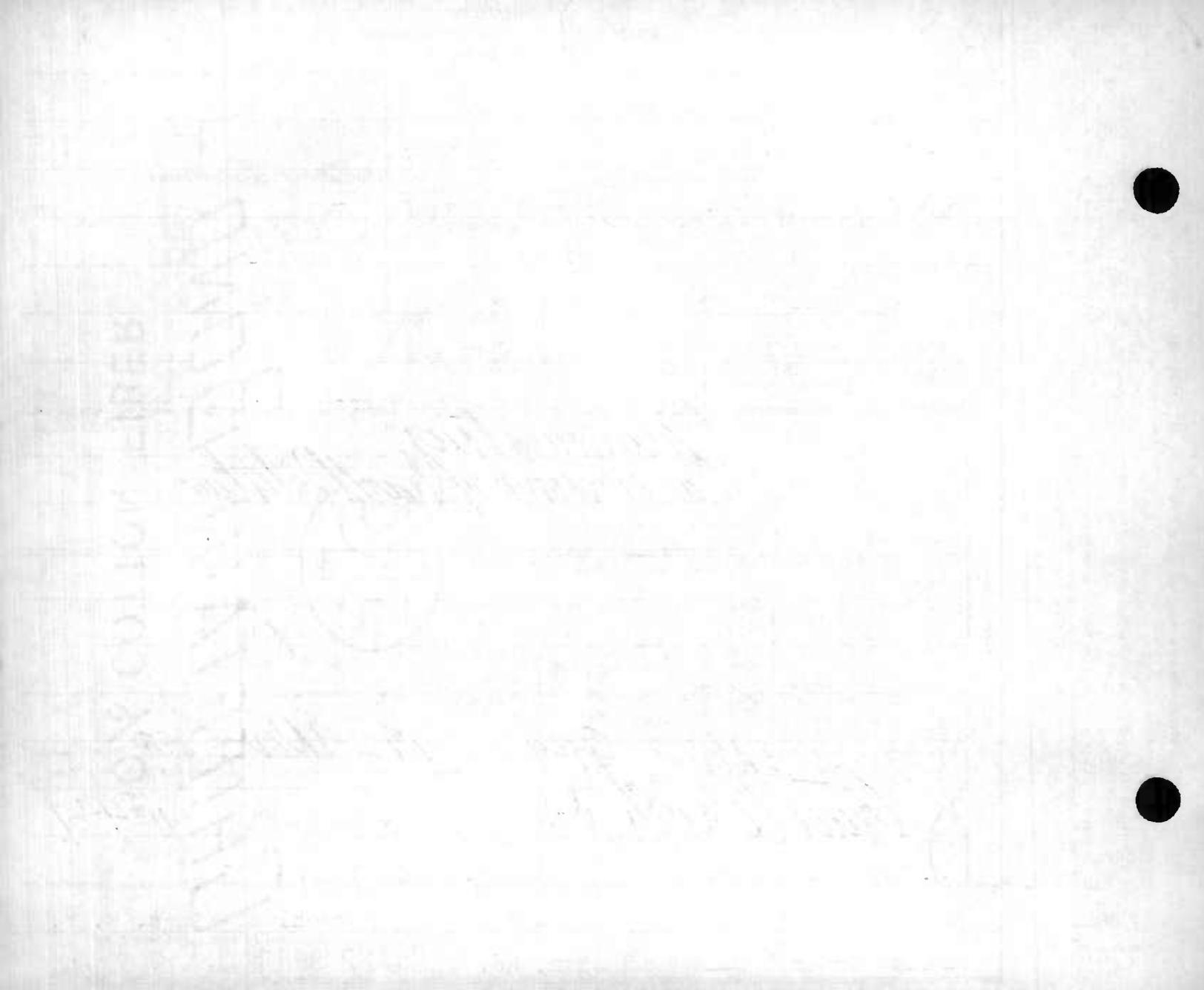


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-tran's permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 5 8	
												REG. NO.	
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			ELIZABETH BARBARA MEYERS						Nov. 4, 1981			2:30 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
female			caucasian			July 10, 1887			94			YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
New York			U.S.						Talbot				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton			House in the Pines			housewife							
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
New York Nassau			Great Neck						27 Elliott Road				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Henry Pfeiffer			Barbara E. Becker										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
						Ruth M. Hoctor			St. Michaels, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for items (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1529 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { DUE TO, OR AS A CONSEQUENCE OF <i>Pneumonia</i> <i>Circumstances of Small Pneumonia</i> { DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from since the deceased alive on 19 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						79 4 Nov. 19 81							
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			11-4-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)													
R. Lane Wroth, M.D.						St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			11-7-81			Evergreen			Brooklyn, Kings, N.Y.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Newnam Funeral Home			Easton, Md.			NOV 12 1981 Jan Wroth							



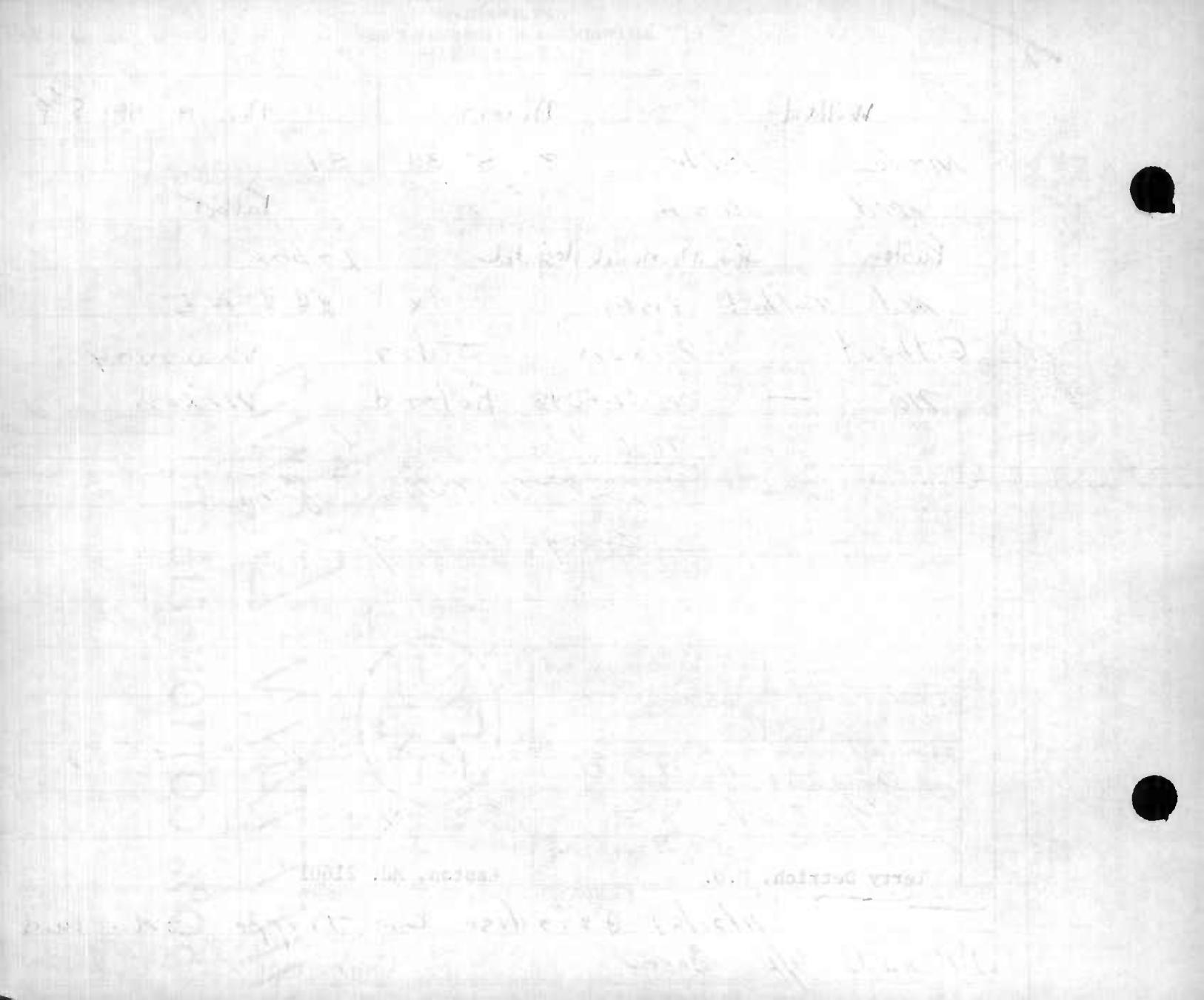
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 5 9				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Willard							Nixon		Nov. 14, 1981						8:30 AM	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male			Blk		MONTH DAY YEAR		51			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md			USA					Talbot								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Easton			the Memorial Hospital									Labor				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md			Talbot		Easton					880-455						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Gilbert					Nixon		Julia					Nixon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No					215-26-5048			Roland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Cancer to Brain</i>																
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { (b) <i>and Cerebellum from</i> (c) <i>Lung Primary</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 14, 1981</i> , to <i>Nov 17, 1981</i> , that (I) (we) last saw the deceased alive on <i>Nov 14, 1981</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Terry Detrich, M.D.</i>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS										
<i>Terry Detrich, M.D.</i>						Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Cemetery			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
11/21/81			11/21/81			Paradise Cemetery			Talbot			Is.	Md.			
24. FUNERAL DIRECTOR <i>JH Daubert</i>			ADDRESS <i>7/1 Easton</i>						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>NOV 20 1981 Jan Nathan</i>				



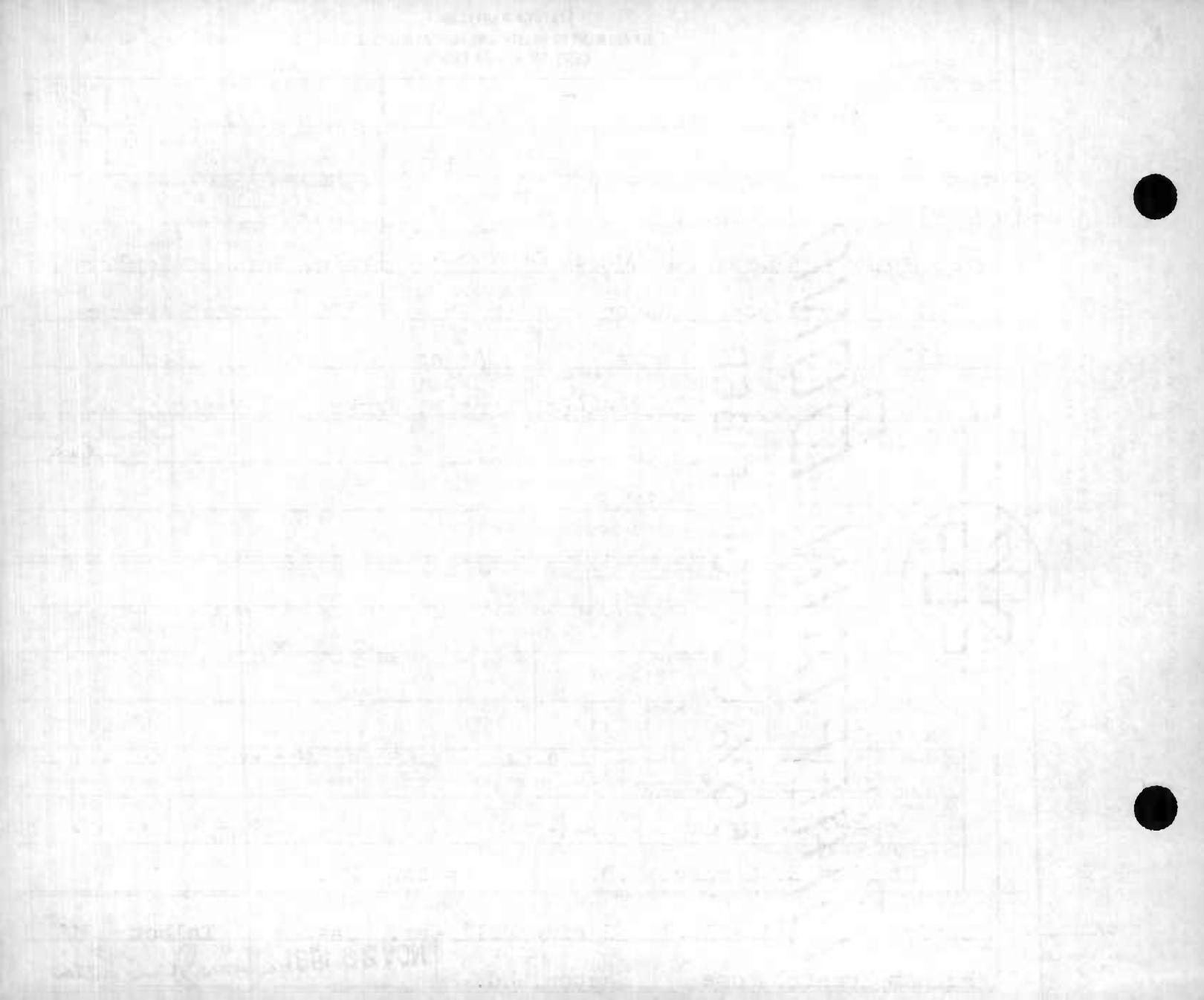
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30260				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Guy W. Parks						11 19 81			9:21 A.M.					
3. SEX			4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)									
m			w	MONTH MAY DAY 8 YEAR 1914	67						IF UNDER 1 YEAR	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.			Talbot			Talbot			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hosp & Easton						Main. Eng.			Poultry		
13a. STATE Md.			13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 108 Prospect Avenue						
14. FATHER'S NAME FIRST Will MIDDLE Parks LAST			15. MOTHER'S MAIDEN NAME Agnes E. Bozman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 215-26-4468			17. INFORMANT Edna M. Parks			ADDRESS Easton, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>  4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>A SH D</i>  DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>  PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 9-30 19 80 to 11-19 19 81, that (I) (we) last saw the deceased alive on 11-19 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE <i>Stephen B. Carney, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-19-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen B. Carney, M.D.			22e. ADDRESS Easton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-21-81			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cem.			23d. LOCATION CITY OR TOWN Easton			COUNTY Talbot		STATE Md.
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25. REGISTRATION BY REGISTRAR NOV 23 1981			26. REGISTRAR'S SIGNATURE <i>James Jan Hartman</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 6 1			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	3b. HOUR			
<i>Kelvin F. Patrick</i>						11-9-81						5 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS				
Female		Caucasian		Oct. 8 1910			71		YRS		MONTHS LEAVE HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Talbot</i>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Easton		<i>Memorial</i>		Housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS						
Md		Talbot		Easton			<input checked="" type="checkbox"/>		704 Goldsborough St.						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
William		R.	Perry	Molly			219-07-3201		Floyd E. Patrick		Boone				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			16d. DEATH WAS CAUSED BY: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4100		16e. DEATH WAS CAUSED BY: PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b)  ASHD		16f. DEATH WAS CAUSED BY: PART III. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)  40ads				
No															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)  (b) ASHD												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)  (b) ASHD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b)  ASHD												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b)  ASHD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART III. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)  40ads												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART III. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)  40ads			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22b. TIME OF INJURY 19 78 to 10 19 81		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22d. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22g. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22h. TIME OF INJURY 19 78 to 10 19 81		22i. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22j. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22k. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22l. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22m. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22n. TIME OF INJURY 19 78 to 10 19 81		22o. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22p. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22q. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22r. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22s. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22t. TIME OF INJURY 19 78 to 10 19 81		22u. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22v. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22w. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22x. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22y. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22z. TIME OF INJURY 19 78 to 10 19 81		22aa. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22b. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22cc. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22dd. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22e. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22ff. TIME OF INJURY 19 78 to 10 19 81		22gg. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22h. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22ii. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22jj. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22k. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22kk. TIME OF INJURY 19 78 to 10 19 81		22ll. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22n. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22nn. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22oo. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22p. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22pp. TIME OF INJURY 19 78 to 10 19 81		22qq. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22q. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22qq. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22rr. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22r. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22rr. TIME OF INJURY 19 78 to 10 19 81		22ss. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22s. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22ss. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22tt. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22t. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22tt. TIME OF INJURY 19 78 to 10 19 81		22uu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22u. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22uu. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22vv. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22v. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22vv. TIME OF INJURY 19 78 to 10 19 81		22ww. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22w. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22ww. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22xx. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22x. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22xx. TIME OF INJURY 19 78 to 10 19 81		22yy. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
22y. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22yy. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22zz. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22z. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22zz. TIME OF INJURY 19 78 to 10 19 81		22aa. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
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22bb. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22bb. TIME OF INJURY 19 78 to 10 19 81		22cc. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
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22jj. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22jj. TIME OF INJURY 19 78 to 10 19 81		22kk. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
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22ll. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22ll. TIME OF INJURY 19 78 to 10 19 81		22mm. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
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22nn. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22nn. TIME OF INJURY 19 78 to 10 19 81		22oo. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
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22rr. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 81 above, (I) (we) did not view the body after death.		22rr. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22ss. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22ss. I certify															

Answer 4 page 5

Answer 4 page 5  
C 924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
should be detached from the hospital or attending physician.

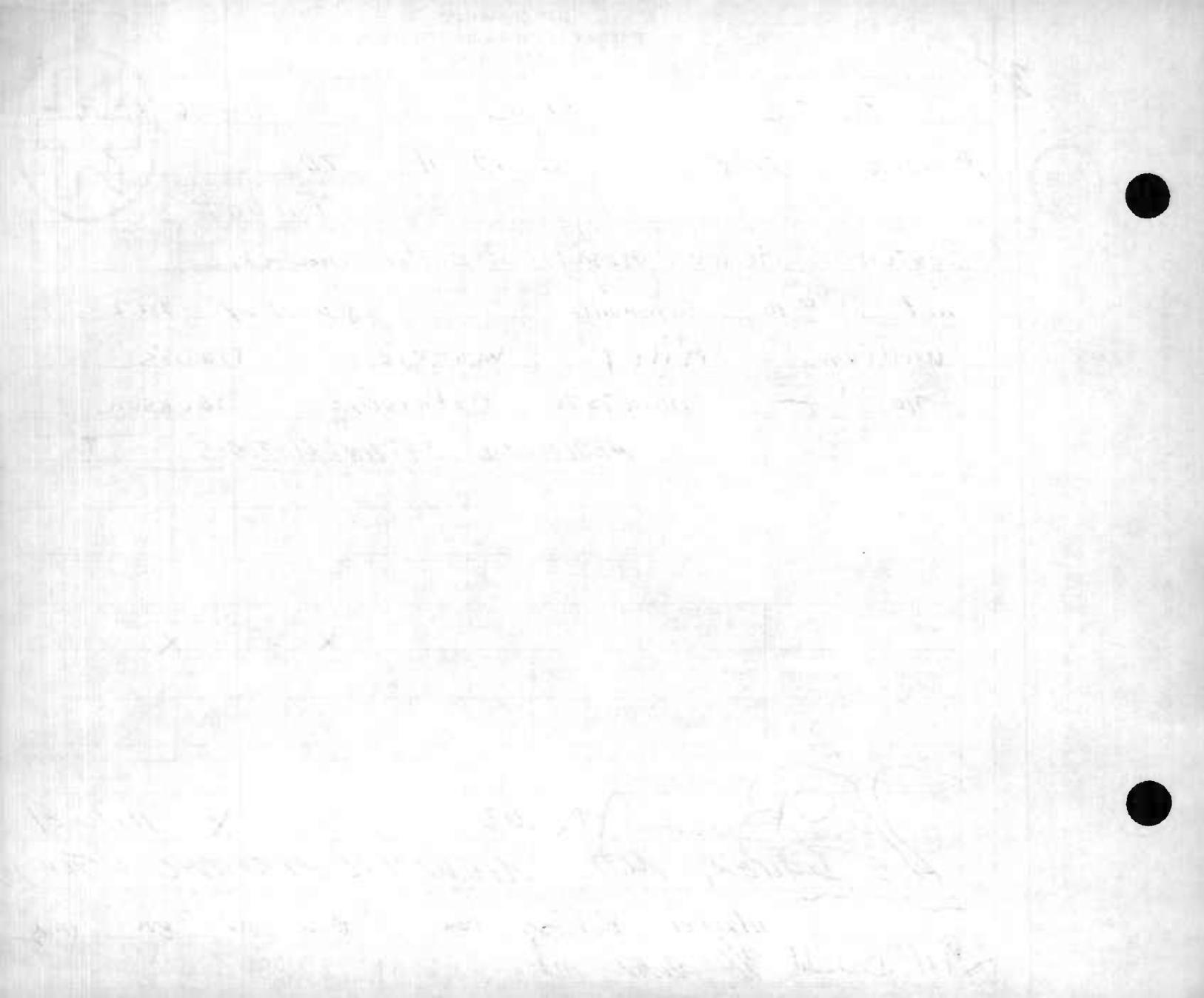
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, it should be detached from the hospital or attending physician. Then phone same carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner shall be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 30262

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Bettie</i>					<i>Pope</i>	<i>11-16-81</i>				<i>10 A M</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>Female</i>		<i>B/K</i>		<i>2 17 11</i>		<i>70</i>		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
<i>Easton</i>		<i>Memorial Hospital at Easton</i>				<i>Talbot</i>					
10. CITY OR TOWN OF DEATH											
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
<i>MD</i>		<i>816</i>		<i>Crossville</i>				<i>P.O. Box 242</i>			
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
<i>William</i>			<i>Riley</i>	<i>Maggie</i>				<i>Davis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>		<i>220-01-7576</i>		<i>Catherine</i>				<i>Jackson</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>ABDOMINAL CARCINOMATOSIS</i>											
DUE TO, OR AS A CONSEQUENCE OF											
{ (b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If we (had) did not view the body after death.											
22b. SIGNATURE <i>H.E. Dwyer M.D.</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN		22e. DATE SIGNED <i>11-16-81</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H.E. Dwyer M.D.</i>		22g. ADDRESS <i>MEMORIAL HOSPITAL EASTON MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>11/20/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Robinson Cem.</i>		23d. LOCATION CITY OR TOWN <i>Prescottville</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR <i>W.H. Dashfield Jr. Boston md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 20 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James Jean Nathan</i>							

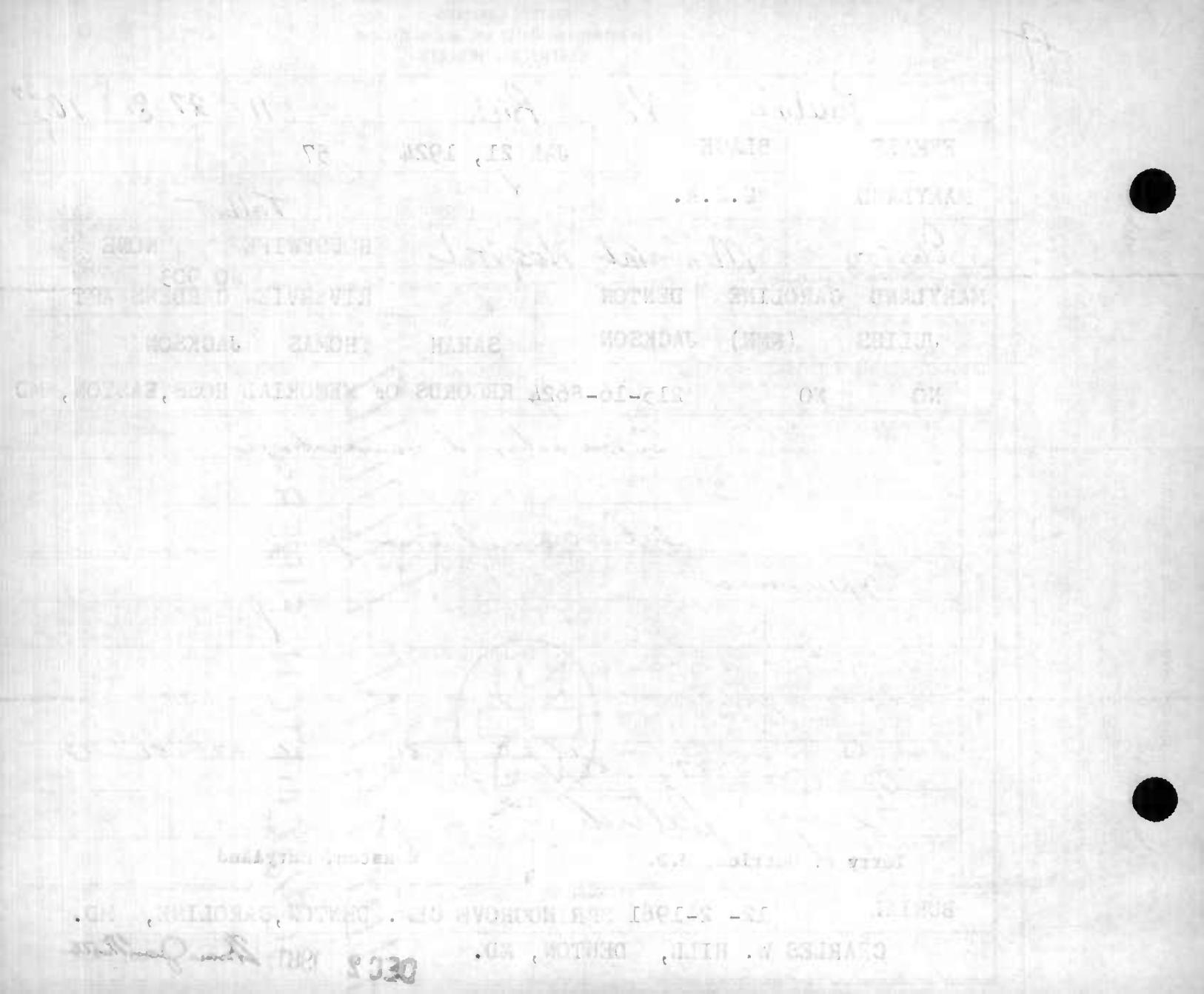


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

IMPORTANT: If Item 21 is marked at Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 6 3		
												REG. NO.		
1 - FOR STATE REGISTRAR			J. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Pauline</i>	MIDDLE <i>V.</i>	LAST <i>Bick</i>	2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR	
									JAN	21	1981	11	27 81	10 PM
3. SEX			4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 2 HRS. HOURS MIN.		
FEMALE			BLACK		JAN 21, 1924		57							
7d. BIRTHPLACE MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			MD.				
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOTE WHICH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>						
13. STATE MARYLAND			13a. COUNTY CAROLINE	13c. CITY OR TOWN DENTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS NO 903 RIVERVIEW GARDENS APT						
14. FATHER'S NAME JULIUS (NMN) JACKSON			15. MOTHER'S MAIDEN NAME SARAH THOMAS JACKSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NO			17. INFORMANT RECORDS OF MEMORIAL HOSP, EASTON, MD			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4300</i>			Subarachnoid Hemorrhage									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b)											
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intra cranial aneurysm</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonia</i>														
20. MEDICAL CERTIFICATION			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>11-23 1981</i> to <i>11-27 1981</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>11-27 1981</i> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <i>Terry P. Detrich, M.D.</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Terry P. Detrich, M.D.			22e. ADDRESS Easton, Maryland											
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12-2-1981			23c. NAME OF CEMETERY OR CREMATORIAL SPRINGGROVE CEM.			23d. LOCATION DENTON, CAROLINE, MD.					
24. FUNERAL DIRECTOR NAME CHARLES W. HILL, ADDR									25a. DATE REC'D. BY REGISTRAR DEC 2 1981			25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i>		

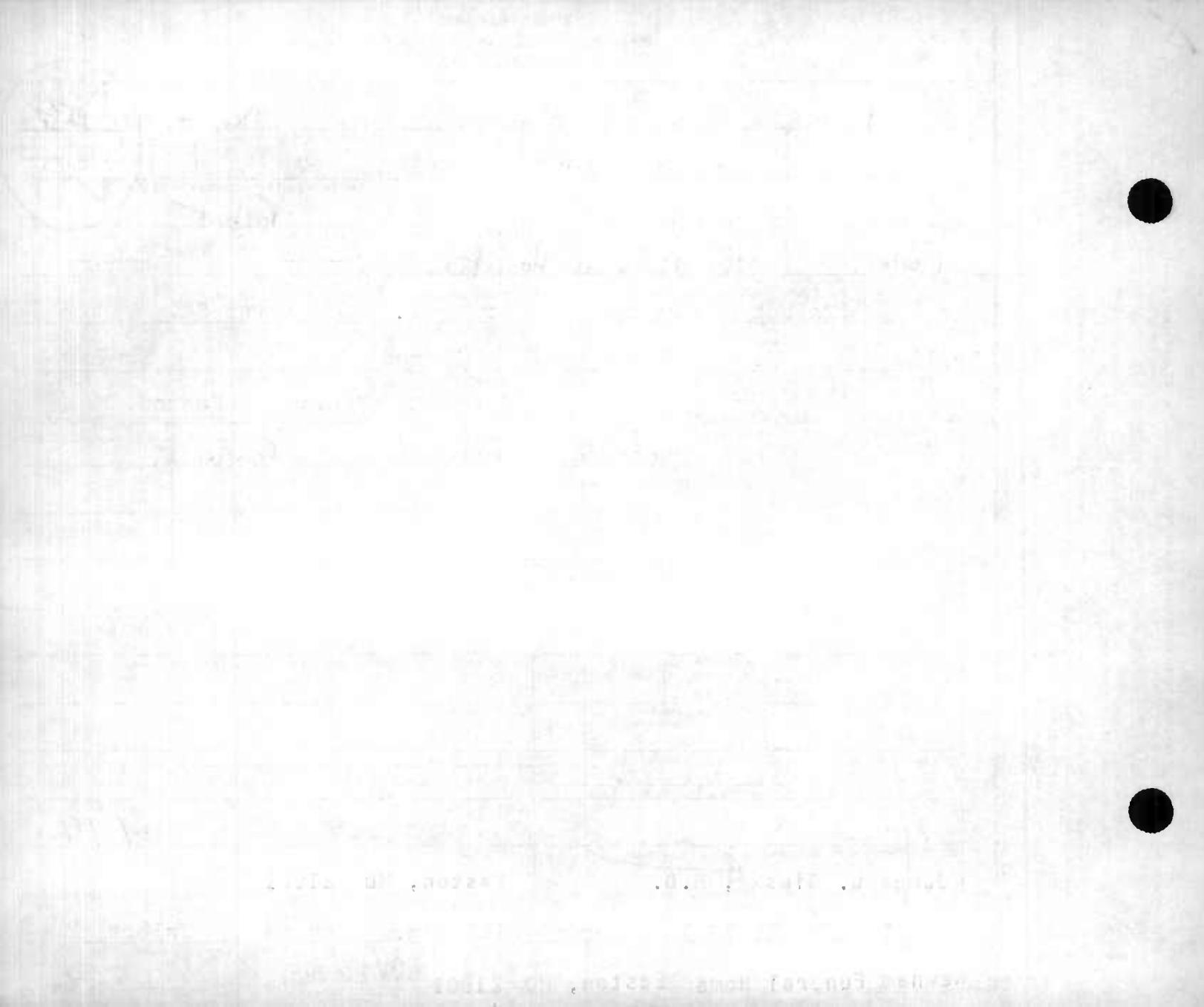


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	3	0	2	6	4							
												REG. NO.													
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
			Katherine M.									Rimmer			Nov. 4, 1981						12 PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			MONTH	DAY	YEAR	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian			OCT			67			Maryland			U.S.A.			MARIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	MONTHS	DAYS	HOURS	MIN.
9. CITY OR TOWN OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME			16b. KIND OF BUSINESS OR INDUSTRY				
Easton			Easton			The Memorial Hospital			ironer			Md Talbot			Md Talbot			LAST Soulsby							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
No			Talbot			Easton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			328 Dover St.			No			218-09-4063			Laura E. Rimmer				
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Metastatic Bladder from Cancer												ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first			DUE TO, OR AS A CONSEQUENCE OF (b)																						
			DUE TO, OR AS A CONSEQUENCE OF (c)																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18																									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 21)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED										
22b. SIGNATURE <i>[Signature]</i>															22c. DATE SIGNED 11/6/81										
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS																						
James C. Gieske, M.D.			Easton, MD 21601																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE													
Burial			11-7-81			Spring Hill Cem.			Easton			Talbot Md													
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																
Newnam Funeral Home			Easton, MD 21601			NOV 12 1981			James J. Nathan																
DHMH - 16 50M 1/81 (VRA 15, 4)																									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81	30265		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Kathleen J.				Roy		11-01-81			11	40	AM		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Fe 2026			BLK		MONTH DAY YEAR			67			IF UNDER 24 HRS		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Md			USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot			YRS		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Easton			Memorial Hospital						Domestic			MD	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Md			9-A		Stevensville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Route #1 Box 285		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Harrison					Johns	Maude					Brewer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Z			214-20-5964		Bessie						UNKNOWN		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian endometrial carcinoma</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (we) attended the deceased from <u>OCT 23 1981</u> to <u>NOV 1 1981</u> , that (I) (we) last saw the deceased alive on <u>OCT 23 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Stephen P. Carney</u>			DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11-2-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			22e. ADDRESS Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>			23b. DATE <u>11/5/81</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Botts Neck Faunry</u>			23d. LOCATION CITY OR TOWN <u>Stevensville 285</u>			COUNTY	STATE
24. FUNERAL DIRECTOR <u>Lynne L. Etter</u>			ADDRESS <u>Etter mdc</u>						25a. DATE REC'D. BY REGISTRAR <u>NOV 9 1981</u>			25b. REGISTRAR'S SIGNATURE <u>Diane Jan North</u>	

1

1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be rebated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8130266
1. DECEASED NAME (TYPE OR PRINT) <b>INDIA B. SAULSBURY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 2, 1981</b>
3. SEX <b>Female</b>				2b. HOUR <b>1 PM</b>
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Maryland</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
10 CITY OR TOWN OF DEATH <b>EASTON</b>				9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b>
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>
13a. STATE <b>Md</b>	13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Trappe</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>R.D. 1, Box 122</b>
14. FATHER'S NAME FIRST <b>Robert</b>	MIDDLE <b>F.</b>	LAST <b>Bryan</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Alverta</b>	MIDDLE LAST <b>Lane</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>214-36-6154</b>	17. INFORMANT <b>Ethel S. Wise</b>	ADDRESS <b>Trappe, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Acute Myocardial infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>				
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b>				
DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 b				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) this hospital attended the deceased from saw the deceased on <b>11/1</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.				
22b. SIGNATURE <b>Donald Lewers, M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED <b>11/2/81</b>				
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>11-3-81</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill Cem.</b>	23d. LOCATION CITY OR TOWN <b>Easton</b> COUNTY <b>Talbot</b> STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b> ADDRESS <b>Easton, Md. 21601</b>				
25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1981</b> 25b. REGISTRAR'S SIGNATURE <b>Jean Hartman</b>				

1955.01.10

1955.01.10

1955.01.10 von 1955.01.10 nach 1955.01.10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of being returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of being returned by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 30261	
												REG. NO.	
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>RAYMOND</u>	MIDDLE <u>E.</u>	LAST <u>SHEERIN</u>	2a. DATE OF DEATH MONTH <u>11/12/81</u>			DAY	YEAR	2b. HOUR <u>1107 AM</u>	
	3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>Jan</u>	DAY <u>18</u>	YEAR <u>1901</u>	6. AGE [IN YEARS LAST BIRTHDAY] 80 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.				
	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>TALBOT</u> MD.									
	10. CITY OR TOWN OF DEATH <u>EASTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MEMORIAL HOSPITAL</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Military Career</u>								
	13a. STATE <u>Maryland</u>	13b. COUNTY <u>Talbot</u>	13c. CITY OR TOWN <u>St. Michaels</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Hamilton Village</u>		12b. KIND OF BUSINESS OR INDUSTRY					
	14. FATHER'S NAME FIRST <u>unknown</u>	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <u>unkn own</u>		MIDDLE	LAST						
	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>Coast Guard 534-16-2378</u>	17. INFORMANT ADDRESS <u>Mrs. Stella George Easton, Md.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u>												
	4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u>												
	DOUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>												
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
	21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
	22a. I certify that (this hospital) attended the deceased from 19 79 to 19 81, that (we) last saw the deceased alive on 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have signed) (and may view the body after death).												
	22b. SIGNATURE <u>William J. Banfield MD</u>												
	22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William J. Banfield, M.D.</u>	22d. DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED									
	23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Nov. 14,</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Holly Cross</u>	23d. LOCATION CITY OR TOWN <u>Greensboro</u>	COUNTY <u>Car.</u>	STATE <u>Md.</u>							
	24. FUNERAL DIRECTOR NAME <u>Harmon Williams - Federalsburg, Md.</u>	ADDRESS	25. DATE REC'D. BY REGISTRAR 75. REGISTRAR'S SIGNATURE <u>NOV 18 1981 Frances Jean Harten</u>										

## Yield Yell

- selling rights

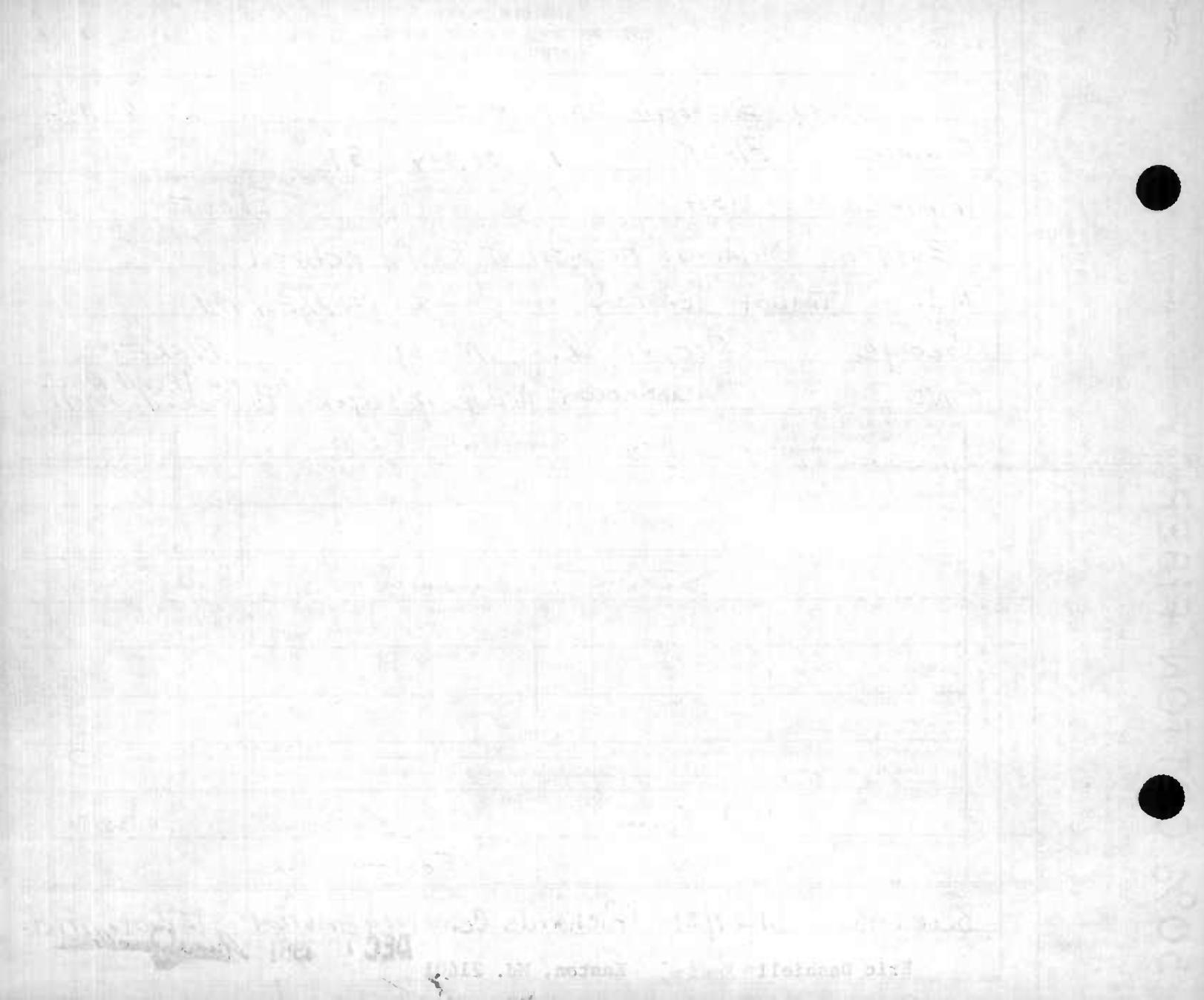
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81	30268				
												REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			11 - 22 - 81			11 15 A.M.		
Mary Elizabeth Sherwood																	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			BLACK			MONTH 1 DAY 21 YEAR 1894			87			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS		
Talbot Co.			USA									Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hospital at Easton									Retired					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.			Talbot			EASTON			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD#4, Box 494					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST			BLAKE					
George			Cooper, Sr.			MARY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			419 Railroad Ave. Townsend, Md.					
NO			Unknown			Arthur, M. Cooper											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour		
5140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Dementia - Blenness																	
18a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
YES <input type="checkbox"/> NO <input type="checkbox"/>												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/20/81, 19, to 11/22/81, 19, that (I) we last saw the deceased alive on 11/22/81, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE C.W. Bain			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/23/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.W. Bain			22e. ADDRESS Easton, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/27/81			23c. NAME OF CEMETERY OR CREMATORIAL Richards Cemetery			23d. LOCATION CITY OR TOWN Easton			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Eric Dashiel & Reese			ADDRESS Easton, Md. 21601			25a. DECEASED BY REGULAR DECE. 1981			25b. REGISTRATION Talbot, Md.								

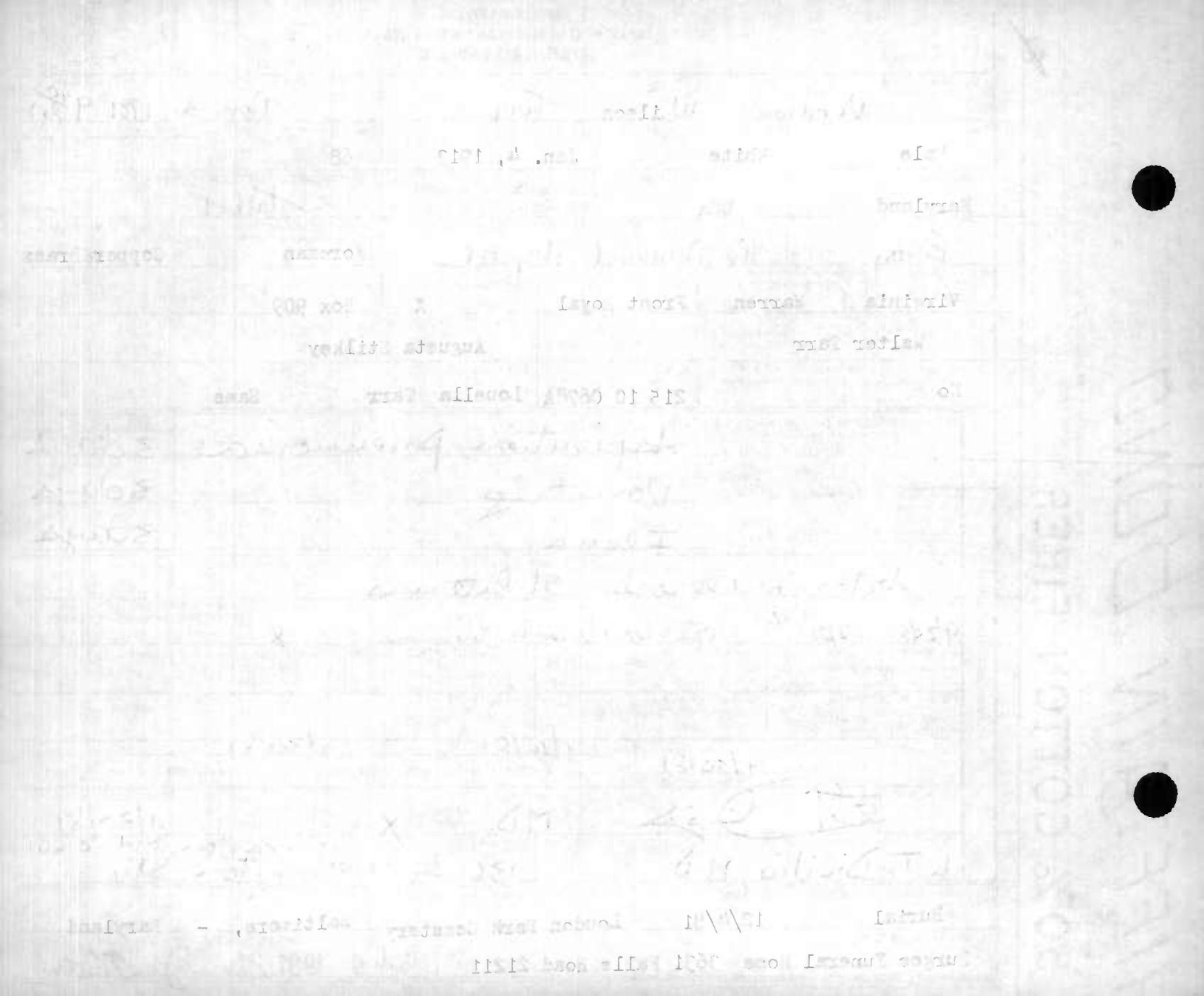


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3 0 2 6 9	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Woodrow Wilson Tarr						Nov. 30, 1981			9:40 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			White			Jan. 4, 1913			68				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			USA						Talbot				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Faison			The Memorial Hospital			Foreman			Copper & Brass				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Virginia			Warren			Front Royal						Box 909	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Walter Tarr						Augusta Stilkey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			215 10 0678A			Louella Tarr			Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5601 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Aspiration pneumonia 3 days	
} DUE TO, OR AS A CONSEQUENCE OF (b) Vomiting 3 days													
} DUE TO, OR AS A CONSEQUENCE OF (c) Ileus 3 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Arteriosclerosis Obliterans													
19a. DATE OF OPERATION 9/23/81 11/2/81 11/2/81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriosclerosis Obliterans			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/16/81, 19, to 11/30/81, 19, that (I) (we) last saw the deceased alive on 9/30/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do) not view the body after death.													
22b. SIGNATURE												22c. DATE SIGNED MD. 11/30/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.T. Divilio, M.D.			22e. ADDRESS 136 S. Washington ST, Easton, MD 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/4/81			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland			23e. DATE REC'D. BY REGISTRAR DEC 4 1981	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home			ADDRESS 3631 Falls Road 21211									23f. REGISTRAR'S SIGNATURE James Jan Wether	
BP _____													
DHMH - 16 50M 1/81 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

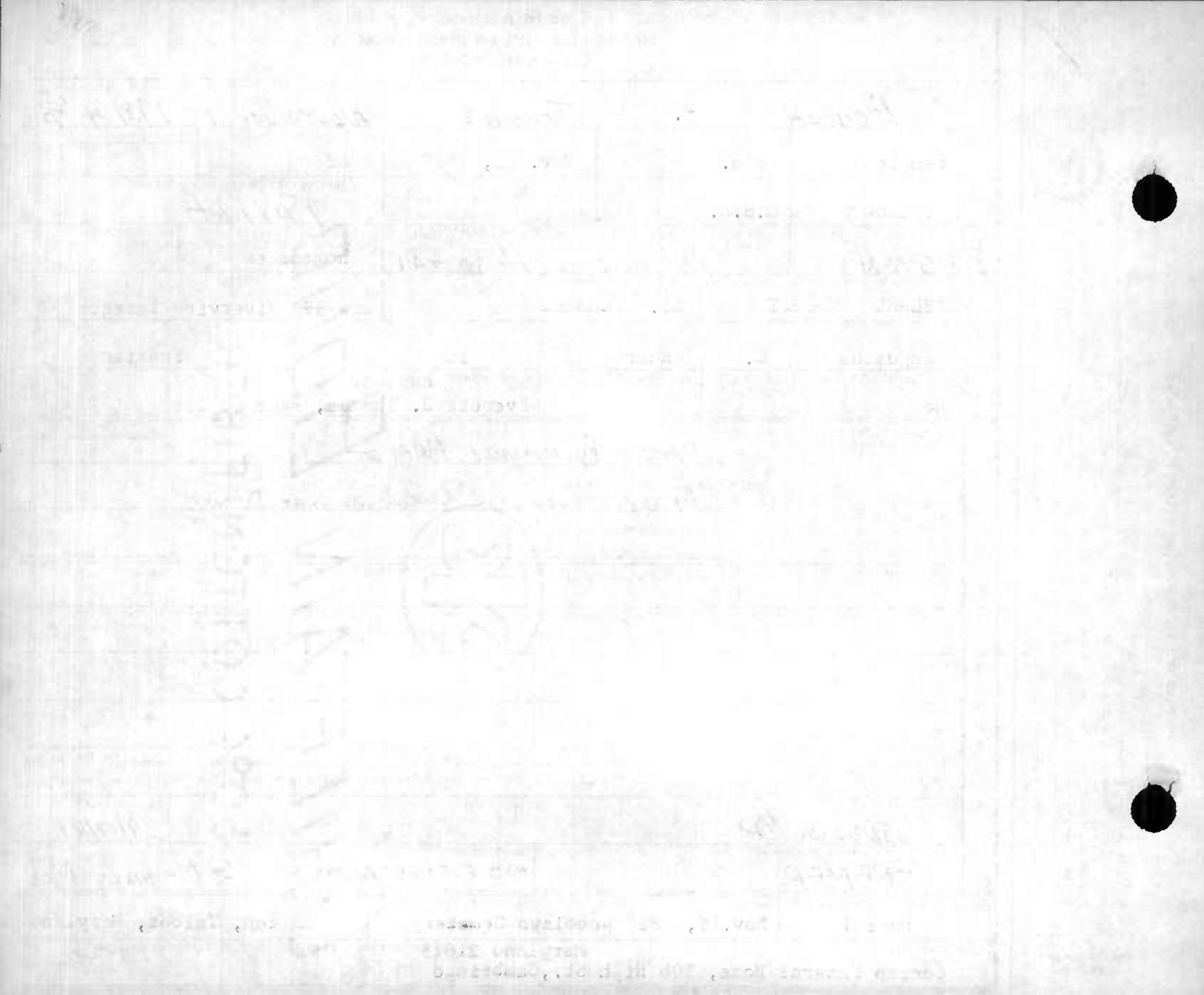
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8130270

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Beulah</i>	MIDDLE <i>E.</i>	LAST <i>Thomas</i>	2a. DATE OF DEATH MONTH <i>Nov. 23, 1898</i>	DAY YEAR <i>1981</i>	2b. HOUR 1/2 M
3. SEX female		4. RACE cau.	5. DATE OF BIRTH MONTH <i>Nov.</i> DAY <i>23,</i> YEAR <i>1898</i>			6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ma ryland</i>		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>	IF UNDER 24 HRS MONTHS HOURS MIN.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY MD.
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>TALBOT</i>	13c. CITY OR TOWN <i>ST. MICHAELS</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Box 39A Riverview Terrace		
14. FATHER'S NAME FIRST <i>Augustus</i>		MIDDLE <i>C.</i>	LAST <i>Ruark</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Ida</i>			LAST <i>Frazier</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.			17. INFORMANT husband	ADDRESS <i>Everett J. Thomas, same as 13e</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4392 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>W. Bremer MD</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/17/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BREMER</i>		22e. ADDRESS 103 E. CHESTNUT ST ST MICHAELS MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 19, 1981		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION CITY OR TOWN <i>Easton, Talbot, Maryland</i>		
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge		25a. DATE REC'D. BY REGISTRAR Maryland 2161 ADDRESS		25b. REGISTRAR'S SIGNATURE NOV 18 1981 <i>Jones, Jan Kithen</i>				



K 6  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8130271								
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR								
			<i>GRACE</i>			<i>B.</i>			<i>TODD</i>			<i>November 23 1981</i>			<i>12 44 A.M.</i>					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 12 HRS.					
Female			White			Nov. 14 1909			72			MONTHS DAYS			HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
Conn.			U. S. A.						<i>Talbot</i>			<i>EASTON</i>			<i>Memorial Hospital</i>					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Employee DuPont Co.																				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) n/a			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-22-8023			17. INFORMANT Clifford Beall			ADDRESS Preston, Md.					
James Oliver Benjamin			Eliza Ferris																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS											
<i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any			<i>Acute Myocardial Infarct</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did (did not) view the body after death.			22b. DATE SIGNED <i>11/23/81</i>			22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS <i>400 Dutchmans Lane, Easton, Md 21601</i>											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Gregor Rhodes MD</i>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 27,			23c. NAME OF CEMETERY OR CREMATORIAL Junior Order			23d. LOCATION CITY OR TOWN Preston			COUNTY Caroline			STATE Md.					
24. FUNERAL DIRECTOR NAME <i>Edna Williamson</i>			ADDRESS <i>Federal Hwy 307</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 30 1981</i>			25b. REGISTRAR'S SIGNATURE <i>Edna Williamson</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 3 0 2 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE HELEN	LAST WALLS	2a. DATE OF DEATH MONTH DAY YEAR 11 15 81	2b. HOUR P 5:15 M		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 20 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>House in the Pines</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>122 N. Harrison St.</b>			
14. FATHER'S NAME FIRST <b>P.</b>		MIDDLE <b>Howard</b>	LAST <b>Hubbard</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b>		MIDDLE <b>Elizabeth</b>	LAST <b>Stevens</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-34-9721</b>		17. INFORMANT <b>Charles B. Walls</b>		ADDRESS <b>Easton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia, suspected</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WKS</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Ascd</b> (c) <b>Sudden</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Sudden</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/13, 1977</b> , to <b>11/15, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Donald T. Lewers MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>11/16/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald T. Lewers, M.D.</b>		22e. ADDRESS <b>Easton, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-18-81</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill Cem.</b>		23d. LOCATION CITY OR TOWN <b>Easton</b>		COUNTY <b>Talbot</b>	STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Frances Jean Hartman</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	3	0	2	7	3	
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	26 HOUR					
MARY			B.	WOOD		11-23-81						10A M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Blk			Month Day Year May 15, 1893			88			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker				MD.	
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12b. KIND OF BUSINESS OR INDUSTRY Seafood											
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN St. Michaels			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 108 N. Talbot St.					
14. FATHER'S NAME FIRST Walter Branham			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Matilda Clayton			ADDRESS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 0-----217-07-1449			17. INFORMANT Alverta W. Hynson, St. Michaels, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Daffone after surgery } DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET OF ILLNESS AND DEATH unlikely years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21/81</u> to <u>10/25/81</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did not) (did not) view the body after death.																	
22b. SIGNATURE <u>Patricia R. Dees MD</u>			22c. DEGREE						22d. DATE SIGNED 11/27/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Patricia R. Dees MD			22e. ADDRESS 400 Dutchmans Lane, Easton, Md 21601														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Nov 27, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Thomas Memorial			23d. LOCATION CITY OR TOWN St. Michaels			COUNTY Talbot		STATE Md.			
GENERAL DIRECTOR NAME Barbara E. Leonard			25a. DATE REC'D. BY REGISTRAR DEC 2 1981						25b. REGISTRATION NUMBER Barbara E. Leonard								
DHMH - 16 50M 1/81 (VRA 15, 4)																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 3 0 2 / 4					
										REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST Ralph		MIDDLE Henry	LAST WOOLFORD	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		<i>Ralph</i>							<i>Woolford</i>	<i>11-22</i>		<i>81</i>		<i>6p</i>	<i>m</i>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 6 HRS HOURS MIN					
Male		White		MONTH June DAY 14, YEAR 1911		70									
7b. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Maryland		USA				<i>Talbot</i>		Custodian (retired)		Public Schools					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		<i>Memorial Hospital</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. #1, Box 92		Custodian (retired)		Public Schools					
13a. STATE Maryland		13c. COUNTY QueenAnne's		13d. CITY OR TOWN Grasonville		15. MOTHER'S MAIDEN NAME		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
						First Mary Middle Elizabeth Last Briscoe									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES)		17. INFORMANT Sister		18. ADDRESS		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		217-28-3203		Mrs. Alice W. Seney,		R.D. #1, Box 92									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain Tumor -</i>															
2396 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hemiparesis &amp; Aphasia</i> <i>Diabetes Mellitus</i>															
19a. DATE OF OPERATION <i>9/11/81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Brain Tumor -</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED <i>AT HOME</i> <input type="checkbox"/> <i>NOT AT HOME</i> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> , 19 <i>81</i> , to <i>11/23</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>9/11</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Edgar A. Bering Jr.</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>11/23/1981</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edgar A. Bering, Jr., M.D.</i>		22e. ADDRESS <i>Easton, Md. 21601</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 25, 1981</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Greenmount Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Hillsboro, Caroline, Md.</i>									
24. FUNERAL DIRECTOR NAME <i>Barton Bros.</i> <i>James H. Barton, Jr., Centreville, Md. 21617</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 27 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James H. Barton</i>											

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TO: HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the physician.

TO: FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be called first.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 3 0 2 7 5			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>M. MARY</i> <i>WRIGHT A.E.</i>				<i>WRIGHT</i>	11 22 81						M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS HOURS MIN			
F		B		2 17 99			82 YRS						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD						
Md		USA											
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION EASTON MARY. HOSP.		12a. USUAL OCCUPATION Domestic			12b. KIND OF BUSINESS OR INDUSTRY						
13. STATE Md		13b. COUNTY 808		13c. CITY OR TOWN Church Hill			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Post o. Box 1			
14. FATHER'S NAME John		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Mary E. G. Webb									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 213-42-2366		17. INFORMANT Betty Whyte			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>													
5751 Conditions, if any, which gave rise to immediate cause (b) <i>Septicemia</i> underlying cause last (c) <i>Cholangitis</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>11/21</i> , 19 <i>81</i> , to <i>11/27</i> , 19 <i>81</i> , that (we) last saw the deceased at <i>11/23</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>M.D. Crowley</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/28/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. D. Crowley, M. D.</i>		22e. ADDRESS EASTON, Maryland											
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE 214/81		23c. NAME OF CEMETERY OR CREMATORIAL EASTON TOWNSHIP			23d. LOCATION CITY OR TOWN EASTON COUNTY MARYLAND STATE						
24. FUNERAL DIRECTOR NAME <i>Roger DeGale</i>		ADDRESS EASTON		25a. DATE REC'D. BY REGISTRAR DEC 9 1981			25b. REGISTRAR'S SIGNATURE Priscilla Jean Hartman						

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